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119 (1) Supreme Court, U.S.
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In the
Supreme Court of the United States

Paul Messer & Dorothy Calabrese, M.D.
Petitioners,

v.

U.S. Department of Health and Human Services
Respondent.

Petition for a Writ of Certiorari
to the U.S. Court of Appeals
for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

Volume 1 of 2

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QUESTIONS PRESENTED

On 07-25-08, in a stay on two cases, the District Court wrote:

"In *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 120 S.Ct. 1084, 146 L.Ed.2d 1 (2000), the Supreme Court clarified and limited the holding of *Michigan Academy*, stating that it stands for the proposition that "§ 1395ii does not apply § 405(h) where application of § 405(h) would not simply channel review through the agency, but would mean no review at all." Based on this narrow reading of *Bowen*, Plaintiffs can only escape the exhaustion requirement if they can demonstrate that completing the review process would mean no judicial review at all. Plaintiffs have failed to make this showing." and

"Plaintiffs rely primarily on the case *Willowbrook v. Olech*, 528 U.S. 562 (2000) as a basis for a waiver of sovereign immunity. See Mem. P. & A., pp. 405. Willowbrook does not address the issue of sovereign immunity at any point in the opinion. Instead, it involves the question of whether the Equal Protection Clause gives rise to a cause of action on behalf of a "class of one" where the plaintiff did not allege membership in a class or group. 528 U.S. at 564. Accordingly, Plaintiffs' reliance on Willowbrook is misplaced."

Whereas our two cases are now stayed pending exhaustion, no matter how long exhaustion takes, no matter how many collateral cases must be exhausted, and no matter what the adverse consequences:

- 1) exhaustion was conclusively decided
- 2) exhaustion is an important issue completely separate from cause of action merits: DHHS pattern and practice of multiple violations of 18 USC § 1001(A)(2), 18 USC § 1001(A)(3), 18 USC § 1035(A), 18 USC § 1621 and 18 USC § 1505 against our Medicare Part B class
- (3) the right to exhaustion is unreviewable on appeal from a final judgment.

Our case should not have resulted in a different ruling than :

Although a district court's denial of a motion under FRCP 12(b)(6) is not ordinarily appealable, the denial of a claim of immunity is appealable before final judgment under the collateral order doctrine and is reviewed *de novo*. *Hydrick v Hunter*, No. 03-56712, WL 2445998, *5. 9th Cir.(2007)

Question 1

Did the Court err in its interpretation that Medicare review provisions make exhaustion unappealable under the collateral order doctrine [*Cohen v. Beneficial Indus. Loan Corp.*], denying Petitioners timely due process?

Question 2

Can our rights under Article III, the Fifth Amendment and 5 USC § 702 be stayed pending exhaustion under *Shalala v. Illinois Council* when there is ongoing irreparable injury and preventable premature morbidity and mortality of our class?

Question 3

Did the Court err in its interpretation of *Willowbrook v. Olech* where petitioners qualify as a class-of-two, denying Petitioners timely Fifth Amendment due process?

Question 4

Did the Court err in refusing a hardship exception under *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967), denying Petitioners timely due process?

Question 5

Did the Court err in refusing a futility exception under *McCarthy v. Madigan*, 503 U.S. 140, (1992), denying Petitioners timely due process?

PARTIES

Petitioners:

Paul Messer, beneficiary

Dorothy Calabrese, M.D., provider

There is no corporation in this case.

Respondent:

Secretary Michael O. Leavitt,

U.S. Department of Health and Human Services
Center for Medicare Services [DHHS CMS].

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[A] Appendix A

- AAAAI** Academy of Allergy & Immunology
ACAAI College of Allergy & Immunology
AHLA American Health Lawyers Association
APA Administrative Procedures Act
BIPA 2000 Medicare, Medicaid & SCHIP Benefits Improvement and Protection Act of 2000
CAC Carrier Advisory Committee
CMB California Medical Board
CMD Carrier Medical Director
CMS Center for Medicare Services
CPS Child Protective Services
FOIA Freedom of Information Act
FTC Federal Trade Commission
GBA Medicare Carrier 09-02-08 to present
LCD Local Coverage Determination
MCSS multiple chemical sensitivity syndrome
MMA 2003 Medicare Prescription Drug Improvement and Modernization Act of 2003
MSBP Munchausen's Syndrome by Proxy
MUSD Murietta Unified School District
NCD National Coverage Determination
NVCA National Venture Capital Association
NHIC Medicare Carrier 12-02-02 to 09-01-08
OMHA Office of Medicare Hearings & Appeals
PPO preferred-provider organization
PF antigens preservative-free antigens
TF transfer factor immunomodulatory therapy
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O P I N I O N S & O R D E R S

First Federal - Due Process

9th Circuit Case 07-56622 filed 10-18-07 [H] appeal of SACV06-01217 [filed 12-15-06]. Case was an appeal of the 10-12-06 DHHS final agency decision. "The Courts are not free to impose an exhaustion requirement as a rule of judicial administration where the agency action has already become final under § 740." *Darby v. Cisneros*.

The Petition before this Court is an appeal of stays on the 2nd and 3rd cases, which are related to the first case.

Second Federal - Due Process

9th Circuit Case 08-56278 final decision 12-08-08 [A] appeal of SACV07-01444 CJC-RNB 07-25-08 stay [C] 04-01-08 Court granted exhaustion [E] then reversed it.

Third Federal - Due Process

9th Circuit Case 08-56358 final 12-05-08 [B] appeal of SACV08-00663 CJC-RNB stay [D]

All three cases are for injunctive and declaratory relief from ongoing Fifth Amendment due process guaranty violations. None are for any monetary damages or claims adjudication.

JURISDICTION

Collateral Order Doctrine: *Cohen v. Beneficial Indus. Loan Corp.* and the Ninth Circuit *Hydrick v. Hunter* permit the appeal of this category of orders.

Fifth Amendment Due Process Clause, *Bolling v. Sharpe*

Article III

Standing as a class-of-two

- preventable premature morbidity and mortality of our class
- allowing majority-opinion allergist immunologists control of policy and reimbursement to exclude minority-opinion allergy-immunology patients.
- pattern and practice of due process violations , including criminal violations, against minority opinion allergist-immunologists
- discrimination against our class reporting symptoms of multiple chemical sensitivity
- discrimination in recognition of our class' diagnosis - hereditary Th1-Th2 immunoregulatory defect which DHHS claims has no medical basis
- discrimination in denying the medical necessity of TF [Th1 specific]
- discrimination in denying the medical necessity of PF antigens [Th2 specific]
- discrimination in recognition of our peer-reviewed literature which DHHS contends is "not in the normative literature."

- discrimination by preferentially weighting agency non-qualified and anonymous experts against our Daubert-qualified experts
- discrimination in agency definition of "generally accepted" as based on a show of hands of the majority instead of the reason and logic of accepted scientific methodology
- discriminatory harm to physician and patient reputation and loss of privacy
- discriminatory anticompetitive actions

Causation

- the injuries are a direct result of DHHS Constitutional (including criminal) violations

Redressibility

- end ongoing preventable premature morbidity and mortality of our class
- restore our class' due process guaranty
- appropriate access to the Rules of Evidence
- restore the rule of law for our class. On 03-06-07, US Attorney Fitzgerald stated:

No one's above the law, no one gets less protection than the law... Mr. Libby did not tell the truth to the system. And when someone doesn't tell the truth to the system, everyone suffers. The legal system suffers, because we don't know what the actual facts are. And, frankly, lots of other people suffer since, when you don't know what the truth is, people draw all sorts of conclusions.

APPLICABLE STATUTES

5 U.S.C. § 702 Administrative Procedures Act

28 USC § 1651(a) The Supreme Court may issue all writs necessary or appropriate in aid of their respective jurisdictions and agreeable to the usages and principles of law.

Fifth Amendment Due Process Clause
which included violations against our class of:

- a. **18 USC § 1001(a)(1)** whoever in the executive branch knowingly willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact.
- b. **18 USC § 1001(a)(2)** whoever in the executive branch knowingly and willfully makes any materially false, fictitious, or fraudulent statement or representation
- c. **18 USC § 1001(a)(3)** whoever in the executive branch knowingly and willfully makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry
- d. **18 USC § 1035(a)** whoever in any matter involving a health care benefit program, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or makes any materially false, fictitious, or fraudulent statements or representations, or

makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits or services

e. 18 USC § 1505 whoever corruptly influences, obstructs, or impedes or endeavors to influence, obstruct, or impede the due and proper administration of the law under which any pending proceeding is being had before any department or agency

f. 18 USC § 1621 whoever having taken an oath before a competent tribunal, officer, or person, in any case in which a law of the US authorizes an oath to be administered, that he will testify or declare, or that any written testimony or declaration by him subscribed, is true, willfully and contrary to such oath states or subscribes any material matter which he does not believe to be true; or in any declaration under penalty of perjury as permitted under section 1746 of title 28, willfully subscribes as true any material matter which he does not believe to be true

g. Medicare, Medicaid & SCHIP Benefits Improvement and Protection Act of 2000 Section 522 structured rules that Contractors must follow for a LCD and national coverage determination development, including consultations with physician organizations in local Carrier Advisory Committees, the posting of proposed LCDs with a comment period, and publishing LCDs

that include data on the evidence used to develop the policy

h. Medicare Prescription Drug Improvement and Modernization Act of 2003 Medicare Ombudsman shall receive and handle complaints from Medicare beneficiaries, report to Congress and identify current problems with the Medicare system.

5 USC § 702 A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action is entitled to judicial review thereof.

F.R.Civ. P. Rule 56(d)(1) If summary judgment is not rendered on the whole action, the court should determine what material facts are not genuinely at issue. The court should so determine by examining the pleadings and evidence before it and by interrogating the attorneys. It should then issue an order specifying what facts - including items of damages or other relief - are not genuinely at issue. The facts so specified must be treated as established in the action.

DISTRICT COURT STAYS

Despite our round-the-clock efforts for over six years, and four years of assistance from the US Department of Justice ATR, we've been unable to secure any rights for our Medicare Part B class which has realized nothing more than the mythology of Tantalus:

- never able to reach the fruit tree with low branches... their Medicare benefits
- never able to drink from the pool of water... the Federal Rules of Evidence.
- never able to live without fear of a threatening towering stone... preventable premature morbidity and mortality.

only because our class has a hereditary Th1-Th2 immunoregulatory defect. We continue to seek justice and as such need to correct and preserve our case in the record.

There has been a sixty-year turf war between majority-opinion allergist immunologists and the minority. In the 70's and 80's the FTC and US DOJ ATR stopped majority-opinion allergist-immunologists from stacking indemnity health insurance review panels so as to obstruct the minority from reimbursement. This was the period where minority-opinion allergy-immunology flourished. In subsequent years, the majority who totally control PPOs, HMOs and ERISA regulated administrated plans routinely shut out the minority or unfairly penalized them by having a lower reimbursement and less favorable deductibles

and other terms. The US DOJ ATR has told DHHS that they cannot make every patient in our class have to appeal on a case-by-case basis in perpetuity, which is an impossible task for these very sick patients. DHHS stated they do not have to listen to the US DOJ because they have sovereign immunity.

This has been an uphill battle because the District Court:

- a) stated it will always believe an officer of the court
- b) wrote on 03-12-08: "While acknowledging Plaintiffs' rights to proceed as pro se litigants, the Court respectfully suggests that Plaintiffs consider obtaining legal counsel to assist them."
- c) wrote a highly prejudicial "factual background" in the stays favorable to DHHS
- d) dismissed our first case with prejudice which meant there was no judicial review
- e) denied us all access the Federal Rules of Evidence in all three cases.
- f) denied due process in our second case and denied Rule 56(d)(1) protections. There is no giant eraser for PACER. Now anyone can quote the District Court statements that are totally inaccurate as fact because there is the automatic presumption Rule 56(d)(1) protections were required.
- g) denied due process in third case where there was no agency response was ever filed in response to the initial complaint, there were no motions or briefs filed by either party, and no hearing. There cannot be a presumption based

entirely on a single complaint filing that there are no exceptions to *Shalala v. Illinois Council*.

h) repeats our filings are ultimately tied to claims' benefits, as if we don't understand. This is a basic requirement for Federal Court standing, unless you are an association. Our orphan class is too tiny to ever have association representation.

The following is a page -by-page response to the 07-25-08 stay:

[Appendix page 6a] Based on a single anonymous medical expert {I}, on 10-30-03, NHIC:

- a) stopped covering all services on all patients:: new patient appointment, follow-up consultations, resuscitations, intradermal allergy testing, PF antigens and TF on all patients
- b) said they were instituting a non-reimbursement LCD (which was published 04-01-04)
- c) made the LCD retroactive for 2001-2003 for all patients for all services
- d) wrote that all the patients should have been referred to a real "allergist-immunologist" in violations of *Bowen v. Michigan Academy of Family Physicians*.

[7a] The DHHS repeatedly pled that DHHS is the only proper defendant to sue, assuming DHHS liability for NHIC and its agents.

[8a] *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, requires reasonable agency action consistent with Congressional intent.

Furthermore, we object to the ‘factual background’ which include false statements while we were denied our rights under Rule 56(d)(1).

[9a] A single obscure DHHS reference to MCSS by the anonymous NHIC reviewer{I} ended up in both the DHHS DAB 10-12-06 final agency decision and the District Court 07-25-08 stays:

Dr. Calabrese specializes in the care
of patients suffering from a pattern
of symptoms known a “multiple
chemical sensitivity syndrome.”
[MCSS]

The DHHS DAB did redact this from their final agency decision. The District Court refused to correct it, characterizing our request to be recognized by our correct diagnosis as an “inappropriate communication” in PACER.

The two LCD appeals are beneficiary-only by law. Even though Mr. Messer had the 10-12-06 final agency decision and no other collateral actions, the District Court has already illegally denied him any judicial review at all in our first case.

[10a] The overpayment is entirely illegal. The previous carrier paid for this care and there never was any published change in policy. All claims on all patients were denied exclusively as “not medically necessary” based on the applica-

tion of the 04-01-04 LCD retroactively in violation of BIPA 2000 Sec 522.

Through the California Bar, Dr. Calabrese wrote to the Gould family after the US Attorney made false representations to the District Court on 07-22-08 resulting in the 07-25-08 stays. Judge Gould's family called Dr. Calabrese and confirmed that he left OMHA terminally ill in early March before the post-hearing briefings. DHHS knows this and knows it is physically impossible for Judge Gould to have written the 06-03-08 order the week before he died.

There had never been any notice of incomplete documentation for the five year before the OMHA hearing. The issue was first brought by Dr. Bruce Quinn at hearing. Subsequently, in the 2nd LCD appeal, NHIC has admitted to removing >5000 pages from the docket before it was sent to OMHA. Petitioners told OMHA it was impossible for three file boxes to be condensed into one.

The NHIC hearing officer denied the hearing affirmed, never reviewed the case, and automatically affirmed the overpayment because NHIC lied to her and told her and CMS Region IX medical staff that Petitioners had lost the 10-12-06 DHHS decision and the services were not covered.

[11a] The long delay was actually based on NHIC's assertion of judicial conservation – that if we prevailed in the LCD appeal, that would take precedence.

[12a] The findings in Judge Koldewey's 06-03-08 ruling::

- a) illegally purport the document to be Judge Gould's and she signs his name by proxy knowing full well Judge Gould left in early March.
- b) contradict facts in evidence
- c) violate Fifth Amendment guaranty to our class
- c) contradict federal and administrative law
- d) obstruct justice

[13a] TF was covered except for multiple sclerosis under the NCD. None of our patients had M.S.

The DAB ruled there was an LCD which under BIPA 2000 Sec 522 reinstates reimbursement – rather than making the issue moot.

The claims of Dr. Quinn's misconduct were made Center for Medicare Advocacy directly to DHHS DAB and our US DOJ ATR attorney, Steve Brodsky agreed:

The [ALJ Richard Smith] decision by allowing NHIC to manipulate the form without retracting the

substance of its coverage rule, violates the language and policy of the Medicare statute and regulations. As shown, this new Review procedure was created to broaden the opportunities for beneficiaries to challenge restrictive Medicare coverage rules. However, under the decision in this case, NHIC will be permitted to continue to apply the current policy although it must inevitably result in the denial of every claim for coverage of Transfer Factor. The Review process will have been evaded by the subterfuge of characterizing the earner's non-coverage policy as something other than an LCD. To avoid this unacceptable evasion of beneficiaries' rights, the ALJ's decision should be overturned and this case remanded with instructions to review the adequacy of the evidence to support the NHIC rule. If the evidence is inadequate to support the coverage rule under the reasonableness standard, the ALJ must find that the challenged NHIC policy is not valid.

*Sally Hart and Vicki Gottlich,
Counsel, Center for Medicare
Advocacy 03-10-06*

[14a] On 10-12-06, the DAB stated:

We have no basis here, however, to presume that the contractor will fail to comply with its responsibilities under the regulations.

The DAB is not omniscient. But we now know for certain that NHIC did fail to comply. Dr. Bruce Quinn under penalty of perjury on 12-06-07 declared he spent the following year creating a 2nd non-reimbursement of TF LCD violating BIPA 2000 Sec 522 criteria for a new LCD. It went into effect on 10-28-08, so there is no question he failed to comply with regulations.

[19a] Petitioners cited The Equal Access to Justice Act (5 U.S.C. § 504; 28 U.S.C. § 2412) in all our pleadings but we have not been able to afford to pay for any attorneys' fees in these two cases. I'm totally overwhelmed by the costs and routinely work 12 hours, seven days a week because of all the pro bono work.

Petitioners continue to assert that Judge Richard B. Gould was a fine and wise judge and would never have written this order. No matter what anyone in DHHS will now say to cover-up and protect their job, all that is left is his memory and that needs to be protected. The District Court's simple verification of Judge Gould's last date of employment at OMHA would have proved the truth. The US Attorney on behalf DHHS lied as he stood before Judge Comac J. Carney declaring that:

- a) Judge Gould was actively working on the decision when he had already left terminally ill weeks before [03-31-08 hearing]
- b) Judge Gould had written the 06-03-08 decision [without fulfilling his promise to petitioners for feedback before his final decision was issued] and that Judge Gould did this before he died on 06-11-08. [07-22-08 hearing]

From the 07-22-08 hearing transcript:

The Court: "I was surprised that another judge could sign that [OMHA] decision. If it was a federal trial in another matter, I think you have to start over."

U.S. Attorney: [Judge Gould] "died on June 11, 2008. That decision is dated June 3, 2008. So he was alive. He may not have been doing well. Judge Gould presided over, as we all know, over the hearing; took the testimony and that was his decision. That's all I can say."

The Court: "All right. So I would imagine if that goes before the DAB, there is going to have to be an evidentiary record to support that Judge Gould did indeed give his authorization to the ALJ to sign his name."

US Attorney: "Whether that's an issue, I don't know."

The US Attorney has a duty of due diligence and can't pursue what Justice Breyer calls "tunnel vision." It is clear the US attorney's originally stated single minded pursuit to preserve the

Medicare Trust Fund from minority-opinion allergy-immunology patients has done more harm than good, cost more to the Trust Fund paying NHIC's attorney alone than the cost of care for all the patients for all services during the same period. The real US Attorney's office motives are more likely that the executive branch wishes to retain absolute power. Irrespective, the US Attorney has crossed the legal line and is party to the two subsequent obstructions of justice:

1) On 06-09-08 he wrote:

"While Dr. Calabrese represented to this Court that Judge Gould had already ruled in her favor, in fact Judge Gould's ruling was the opposite. This must call into question Plaintiff's characterization of events in various administrative proceedings upon which Plaintiffs have sought to base allegations of criminal conduct herein."

to impeach Dr. Calabrese to gain unfair advantage in SACV07-01444 CJC-RNB.

2) On 07-22-08, he stated to the District Court that after the MAC and 2nd LCD cases (and any new cases including any of the 2003-2009 claims never paid) receive final agency decisions, the US Attorney said: "There would be a waiver of sovereign immunity for the purposes of a record review of the decision."

He added: "there will only be 90 more until the matter will be finally decided. [by the MAC] I don't think those time frames are unreasonable here. . ."

- 1) not only have all our cases been destroyed by the criminal violations, the US Attorney insists the Court is then limited only to review of a closed DHHS record only.
- 2) this position clearly violates petitioner's obligation to submit timely Medicare claims because filing anything will trigger new cases where the US Attorney insists all must be exhausted before any can be heard – a practical prohibition on future right to appropriate legal redress.
- 3) Last month, Mary Peltzer at the MAC, verified that neither the US Attorney or DHHS told the MAC that Judge Gould had left OMHA in early March or that Judge Koldewey authored the 06-03-08 decision.
- 4) The US Attorney "ignores" the real possibility of remand by the MAC for the 06-03-08 decision not having proper legal or evidentiary basis. And how can there ever be a remand back because ALJ Koldewey is the boss of all the OMHA ALJ's in our region?
- 5) It has been more than 90 days and our MAC case hasn't even been assigned to an ALJ.

[20a] The District Court writes: "Summary judgment is proper if the evidence before the court "show[s] that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." But these were partial summary judgments, and we were denied Rule 56(d)(1) in the second case and there were no motions at all in the third case or Rule 56(d)(1) protection.

[22a] The District Court relies on: "The United States, including its agencies and employees, can be sued only to the extent that it has expressly waived its sovereign immunity."

The accumulation of all powers, legislative, executive, and judiciary, in the same hands, whether of one, a few, or many, and whether hereditary, self appointed, or elective, may justly be pronounced the very definition of tyranny.

James Madison

The Federalist No. 47

January 30, 1788

[29a] Plaintiffs' prayer for relief is to access the Federal Rules of Evidence.

[31a] *Kaiser v. Blue Cross of California*: In a prior uncontested case, the Kaisers knew they had been overpaid by more than one million dollars and requested an extended repayment plan. Petitioners are outraged at the District Court totally unsubstantiated presumption of guilt: "Just as the court reasoned on Kaiser, "[h]ad the [plaintiffs] never accrued an overpayment in the first place, they never would have brought this case."

[35a] The District Court writes: "In order to support their argument that Judge Koldewey's fraud resulted in a negative benefits ruling, Plaintiffs have to prove that Judge Gould would

have ruled that Plaintiffs are entitled to coverage of transfer factor treatment." This is impossible because Judge Gould didn't even have the complete record before he left OMHA in early March terminally ill. Furthermore, he promised on the record that the parties could weigh in as his decision evolved in future months. We were immediately entitled to a second fair hearing. The fact is that this District Court denied us the NHIC in-person fair hearing in violation of *Schweiker v. McClure* . stating we had to exhaust all 5 levels of appeals before we could appeal being denied the fair hearing. But similarly situated Medicare Part B physicians and patients are not denied timely fair hearings in this way.

And isn't our argument equally plausible: that Judge Koldewey would never have obstructed justice if the agency due process violations had never occurred which is hopefully true for similarly situated physicians and patients?

[40a] There will never be a "much more complete record on which to rule" because it is uncontested that >5000 pages were removed by NHIC. The six year record has already gone from ripe to rotten with unchecked false statements, false entries, false documents, perjuries and obstructions of justice. The record hasn't been properly consolidated because we were denied the two fair hearings and forced to file additional three administrative and three federal court actions. The records are all exploded be-

cause of endless repetitions within and among all the records to preserve each of the cases on appeal.

To the Ninth Circuit, we previously addressed the stay 07-25-08 citations in Appendix W that are not material to our Fifth Amendment cases including:

- *Heckler v. Ringer*
 - *Baker v. U.S.*
 - *Bodimetric Health Services, Inc. v. Aetna Life & Casualty*
 - *Bowen v. Georgetown University Hospital*
 - *Califano v. Sanders*
 - *Clarke v. Securities Industries*
 - *Hironymous v. Bowen*
 - *Kaiser v. Blue Cross of California*
 - *U.S. v. Mitchell*
 - *U.S. v. Nordic Village*
 - *Tucson Airport v. General Dynamics Corp*
-
-

STATEMENT OF THE CASES

In 1940, a Negro arrives at the Pearly Gates. St. Peter asks his name. "Rastus Brown" the Negro says.

St. Peter looks in the good book and says "Rastus, I don't seem to have you listed here. Where are you from?"

"St. Peter, I'm from Athens, Georgia where I was a member of the Athens White Church of Jesus."

St. Peter, "Rastus you're a Negro from Georgia and you want me to believe you were a member of the Athens White Church of Jesus?"

"Yes sir, St. Peter, you see - one day I went to the minister and told him that I'd like to be a member of his church." He said: "OK Rastus, you come back tomorrow for your full baptism."

So I went back the next day and was baptized. The minister had three of the members take me out into the river. They dunked me once, as the minister said, "I baptize you in the name of the Father."

And when I came up he said "Are you OK Rastus."

I said "Yessir."

Then a second dunk and I heard him say "...and of the Son".

Then they lifted me up he asked "you OK Rastus?"

I said "yessir."

Then came the third dunk.

St. Peter: "Then what, Rastus?"

"You know, that's about the last thing that I do remember"

What some called "baptism" for Rastus was
18 USC § 1111.

What DHHS calls justice for our class-of-two is 18 USC §1621, 18 USC § 1505, 18 USC § 1305(a), 18 USC § 1001(a)(1), 18 USC § 1001(a)(2), 18 USC § 1001(a)(3), and denials of ombudsman intervention and fair hearings.

As with Rastus, our class is treated as a joke. For both Rastus and our class, we are treated differently only because of who we are genetically. And what if Rastus was Rastus Brown, M.D., Medicare Part B provider, a minority-opinion allergist, and his due process cases were stayed as ours are?

Will Dr. Brown come back to the District Court half-drowned or never make it back at all? Would his patients prevail in an LCD appeal and then be forced by Federal Court to do it all over again without cause? Would his closed administrative record on judicial review, replete with a pattern and practice of endless due

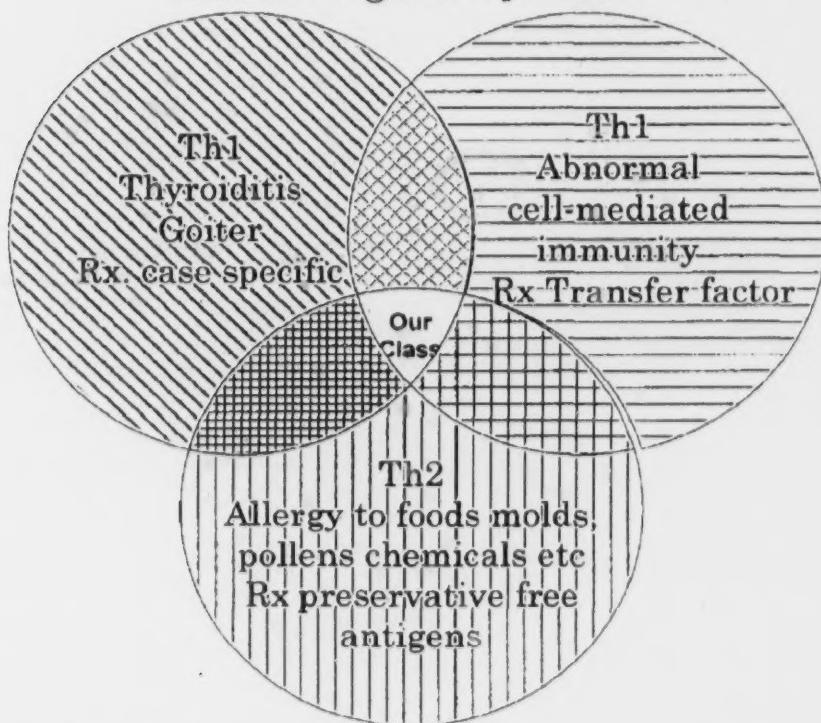
process violations, be ripe or rotten? Can there ever be redressibility for the seven years of his personal and professional life stolen in the process? And what of the sanctity of life of his Medicare Part B patients, for whom Medicare is their only insurance by law?

As a first grader, I gasped in horror when I first heard the Rastus "joke" told at an informal gathering by a clergyman. Yet in six years, no one except our patients have gasped in horror at the cruel "joke" DHHS has played on our class.

Petitioners have a right to the Federal Rules of Evidence and appropriate discovery. . . the first ray of Brandeis' sunshine to pierce the thunderclouds in this unimaginable storm that has caused and continues to cause unconscionable harm to innocent patients in our class.

Village of Willowbrook v. Olech

Combined Th1 - Th2 cytokine-mediated immunoregulatory defect



Patients lie outside the usual spectrum of disease – outliers

Three separate, unrelated genetic defects

Allergic hypersensitivity to foods, molds, chemicals, pollens and so forth

Abnormal cell-mediated immunity - an immune deficiency in specific T cell cytokine-mediated pathways

Many allergic-immune symptoms such as recurrent infections, severe food allergy and intolerance, failure to thrive, anaphylaxis,

asthma, and so forth that affect multiple organ systems.

The severity of symptoms is progressive and adversely affects a patient's abilities to perform significant activities of daily living.

Patients referred by their physicians, including allergist-immunologists or family members who are established patients

Transfer factor immunomodulatory therapy attending physician custom prepared dialyzable leukocyte extract from thirty-three pooled human donors from a licensed non-profit California community blood bank. [Th1 specific]. It is approved and regulated by California Medical Board as medically necessary for our orphan class.

Preservative-free antigen immunotherapy is custom individual frozen aliquots of foods, molds, pollens etc. [Th2 specific]; approved and regulated by the California Medical Board as medically necessary for our orphan class.

Peer reviewed citations from top academic centers

Daubert-qualified expert; Alan S. Levin, M.D., J.D. Certified Diplomate of the American Board of Allergy and Immunology (1975-present), the American Board of Pathology-Clinical Pathology (1977-present), founding member of the American College of Emergency Medicine; served on the California Medical Board 1982 - 1987 and 1990 - 1993; Emeritus Associate Professor UCSF; used PF antigens and TF in our orphan class for decades in private practice in SF

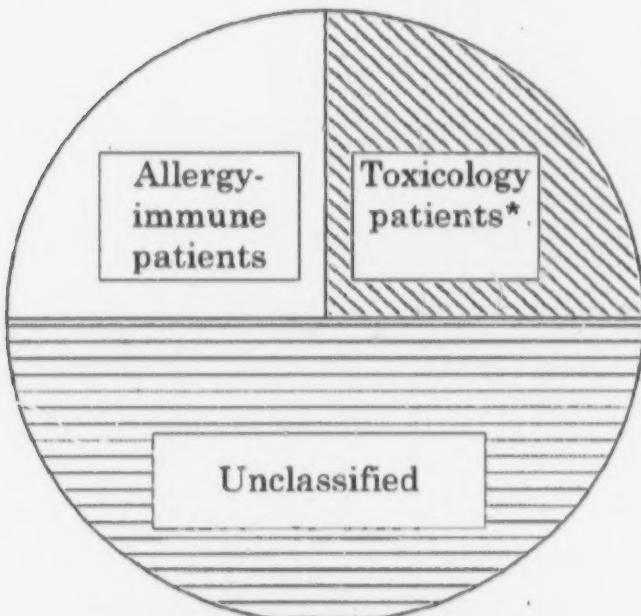
Daubert-qualified expert; Douglas S. Sandberg, M.D., Emeritus Professor of Pediatrics at the University of Miami Medical Center, Jackson Memorial Hospital; practiced at U of Miami for more than four decades; Chief of Gastroenterology and Nutrition including the Allergy and Nutrition Unit; Daubert-qualified expert. {N}

Daubert-qualified expert; Charles H. Kirkpatrick, M.D. Professor of Medicine and Director, Adult Immunodeficiency Program at the University of Colorado Health Center - National Jewish Medical and Research Center, Daubert qualified expert

MCSS is the wastebasket of patients who report symptoms when exposed to ambient chemicals, normally well tolerated by healthy individuals, but do not yet have a specific diagnosis with identified underlying pathophysiology, and therefore no specific treatment. This wastebasket group includes but is not limited to

- 1) nascent autoimmune endocrine diseases
- 2) the prodrome of certain malignancies
- 3) schizophrenia and other thought disorders
- 4) malingering and "litigation syndrome"

* acquired chemical sensitivity from acute and/or chronic toxic chemical exposures involves multimillion dollar toxic torts and product liability suits, where attorneys and majority-opinion allergist-immunologists joust to annihilate any physician who claims the symptom of chemical sensitivity even exists.



Chemical Sensitivity Patients
in Canada Epidemiology
Gail McKeown-Eyssen, M.D.
University of Toronto

*See: Johnson, C., When Science is Too Daunting:
Multiple Chemical Sensitivity, Federal Courts,
And the Struggling Spirit of Daubert; 11 Vill.
Envtl. L.J. 273*

Our case received four years of U.S. Department of Justice Antitrust oversight so we could make it to federal court. Independent AHLA attorney, Jonathan Schuman, former Attorney with the Office of General Counsel, Medicare Part B, Baltimore Central Office, volunteered to our US DOJ attorney, Steve Brodsky, that he would come forward with a map of the longstanding DHHS practice and pattern of this selective cor-

ruption against minority-opinion allergist-immunologists, if he is given Florida Bar immunity, as part of this information derives from his client work. This information was confirmed by AHLA attorney Tim Blanchard, who also consulted on our case. See:

Blanchard, T., *Medicare Medical Necessity Determinations Revisited: Abuse of Discretion and Abuse of Process in the War Against Medicare Fraud and Abuse*, 43 ST. LOUIS U.L.J. 91 (1999) and

Blanchard, T., *Medical Necessity Denials As A Medicare Part B Cost-Containment Strategy: Two Wrongs Don't Make It Right Or Rational*, 34 ST. LOUIS U.L.J. 939 (1990)

Because we won a final agency decision on 10-12-06, Mr. Schuman didn't need to testify because we then had access to Federal Court.

- 1) We are a class-of-two. There are 36 patients in our class who have participated in the two LCD cases.
- 2) Neither the District Court or DHHS has denied our class-of-two Fifth Amendment status.
- 3) Our class is treated differently than those similarly situated in Medicare Part B
- 4) There is no rational governmental basis for the difference
- 5) There is ill will

LCDs are not retroactive

New LCDs may not be implemented retroactively

Medicare Program Integrity

Manual 13.7.4 04-09-04

1st LCD Appeal reinstated reimbursement

1) Federal Register Vol 68, No 216 11-07-03

§426.420(b):

Revising a LCD under review to remove the LCD provision in question has the same effect as a decision under 426.460(b) That the provisions were not valid under the reasonableness standard.

Congressional intent in BIPA 2000 Sec 522

Congressional intent in BIPA 2000 Sec 522 is pellucidly clear:

If Congress had wanted beneficiaries to have the ability to challenge his or her own claim rather than the underlying policy, Congress would have only altered the existing claims adjudication process. However, the whole point of the Benefit Improvement and Protection Act coverage provisions was to have a successful appeal by a single beneficiary create policy for others, much like the Supreme

Court Rulings become the new law of the land.

Letter from Bill Thomas (Chairman, Committee on Ways and Means), Charles B. Rangel (Ranking Minority Member), Nancy L. Johnson Chairman, Health Subcommittee) and Pete Stark (Ranking Minority Member) to Tommy Thompson and Tom Scully, September 27, 2002.

This is also reflected in the Federal Register:

Review of an LCD or NCD requires examination of an entire policy, or specific provisions contained therein, and not just one claim denial. Therefore, such reviews may lead to changes that impact other beneficiaries if the policies are found to be unreasonable. A beneficiary, thus, may elect to pursue a claims denial through the claims appeal process, seek review of an LCD or NCD using the process in this final rule, or both.

*Federal Register: November 7, 2003
(Volume 68, Number 216)] [Rules
and Regulations] [Page 63691-
63731]*

Difference in Treatment - 1st LCD

DHHS Policy	Petitioners
Ombudsman	Denied
CAC	Excluded
Venture capitalists get quid pro quo LCDs	no quid pro quo
PAC to buy your code	no PAC
pay-to-play	refused 11-20-03
1 st Non-reimbursement TF LCD	effective 04-01-04
no LCD docket	reinstates reimbursement
Joint LCD Appeal	filed 02-05-05 32 appellants
Level I 90 days	10 months
Level I violations NHIC Carlos Rivera	18US§1001(a)(1) 18US§1001(a)(2) 18US§1505
Level II 90 days	10 months
Level II Violations NHIC Dr. Bruce Quinn	18US§1001(a)(1) 18US§1001(a)(2) 18US§1505
Final agency decision LCD redacted	Reverses the policy
LCD never retroactive	LCD retroactive 2001-2003
Non-reimbursement policy reversed under BIPA 2000 Sec 522	Sub rosa policy continued

Difference in Treatment – 2nd LCD

DHHS Policy	Petitioners
2 nd Non-reimbursement TF LCD	effective 10-28-07
LCD Complaint	filed 10-31-07
ALJ says LCD appeal required for jurisdiction	filed all scientific evidence >5000 pages
LCD appeal accepted	01-31-08
LCD docket filed	no written work product
Level I 90 days	>14 months no discovery no pre-hearing no hearing 12 appellants
Level I violations	18US§1001(a)(2)
	18US§1001(a)(3)
	18US§1505

Difference in Treatment – Claims

DHHS Policy	Petitioners
2001-2003 retroactive overpayment appeals	Illegal under BIPA 2000 S522
Level I 45 days	1 year
Level I violation	18 USC § 1035
Level I	Secret patient Questionnaires
Rejection of claims	All
Rejection new patients	All
Level II 60 days	1 year appeal
Level III 60 days	27 mos appeal
Level III hearing	denied
Level III docket	>5000 pages NHIC removed
State investigation	no violations
Level IV 90 days	1 year appeal
Level IV decision	ALJ left terminally ill OMHA coverup
Level IV 2 nd hearing	Denied
Level IV violations	18US§1621
	18US§1001(a)(2)
	18US§1001(a)(3)
	18US§1035(a)
	18US§1505
Level V 90 days	>90 days appeal
Process to date	>>6 YEARS

There is intentional and repeated ill will by NHIC's Dr. Bruce Quinn:

my best judgment is that [Dr. Dorothy Calabrese] actually cannot tell right from wrong or fantasy from reality regarding her extremely bizarre medical treatments. She actually seems to believe e.g. that Senator Feinstein wants my personal medical license revoked, and so on. That the U.S. Department of Justice actually will very soon put NHIC executives in prison, and so on. So possibly there is a *limitation of liability* issue involved. And

I believe Dr. Calabrese's extraction of unknown blood fractions from unknown donors into patients flatly violates section 1602 of the California Health and Safety Code, making further questions of medical necessity moot. (This assumes Dr. Calabrese is not a California licensed blood bank.) The section regulates both transfusions and blood product derivatives.

Furthermore, our US DOJ attorney received this:

I do not see justification to revise our non-coverage of transfer factor. . . However, I would like to emphasize to you that Medicare has a simplified process through which manufacturers and providers, certainly including minority-opinion providers, may request a National Coverage Decision.

Dr. Bruce Quinn 12-01-04

The DHHS DAB asked for a response from the contractor to: "At issue: While NHIC purports to have retired the non-coverage policy on transfer factor, its article continues to state a position that amounts to the same bar on coverage for any condition. We will permit the parties to make submissions on this Question. Dr. Bruce Quinn responded:

Coding guidance is not an LCD. . . An article cannot be used to adjudicate medical necessity. Unlike an LCD, the final article could be used to correct billing on future claims, but it would be impossible to employ the article to adjudicate medical necessity on future claims. Contractor 'consistency' versus LCD. The definition of LCD is telegraphic - "a coverage decision" applied 'throughout a geography.' Most claims are always reviewed outside of NCDs or LCDs, but consistency may be observed. One would

hope that on pairings of similar treatment, condition, and patient, the results would tend toward consistency (1). Take as a hypothetical, we would deny a claim for a copper bracelet to treat cancer yesterday or tomorrow, and throughout our geography, whether San Diego or Sacramento. If we railroad the telegraphic regulatory definition of LCDs to impute a de facto LCD every time several claims are decided consistently, or likely to be decided consistently, this yields an absurdity which was not the intent of regulations defining an LCD. There would be an inferred LCD for copper bracelets, if we denied a claim yesterday in San Diego and today in Sacramento. But there would also be millions of implied LCDs existing willy-nilly all across Medicare, appearing whenever any several claims reflecting similar treatments for similar individual patients are adjudicated consistently. Instead, an LCD or NCD must at the least be a published rationale which can be "used", which can be referred in future adjudications as the rationale for non-coverage (or coverage)."

Bruce Quinn, MD 05-06-06

Steve Brodsky, our US DOJ attorney, called Dr. Bruce Quinn's lie to DHHS DAB changing the issue from policy to coding: "transparent"

Meanwhile Dr. Bruce Quinn has already flipped to work for Foley Hoag LLP, the firm through which he offered "special LCDs" only for billionaire NVCA members to avoid the extreme expense and resources required for a NCD, while demanding our class do a NCD and writing two fraudulent LCDs against our class. And NHIC uses these bogus overpayments, including ours to enhance their 2007 rebidding profile for our \$400 million regional Medicare contract. They lost our contract, but were given the entire northwest instead.

Exhaustion serves many important purposes, including functioning as a tourniquet to slow the flow to District Courts and refine the federal jurisdiction questions. But in our cases, the tourniquet has been both misapplied and applied for too long, which inevitably leads to amputation of a limb.

Shalala v. Illinois Council v. Petitioners

On its face, in *Shalala v. Illinois Council*, this Court found that under the Medicaid Act, a litigant could not mount a pre-application challenge to agency rules in ruling: any presumption in favor of preenforcement review must be far weaker than a presumption against all such review." The differences with our class:

Illinois Council	Petitioners
affects 100 % of all Medicare nursing home patients for all services at that facility	affects 100 % of all minority-opinion allergy-immunology Medicare patients for all services, new pt. appt, consults, resuscitations, allergy testing, PF antigens, TF anywhere in CA and our region
patients can choose another nursing home; nursing home can choose non-Medicare pts	DHHS doesn't recognize our class' diagnosis or treatment & they have no other choice of insurance
Part A Major contractual protections	Part B Claims are not "trivial" when LCD illegally applied retroactively to 2001-2003 on every patient for every service for 3 years with interest and penalty

no presentation to DHHS	final agency decision 10-23-06, every issue presented to DHHS for years and rejected
not ripe	won 1 st LCD appeal on medical necessity, then forced to do individual claims determinations on all patients for medical necessity despite the win and DHHS immediately rewrote the same non-reimbursement LCD again on medical necessity as a 2 nd LCD
not futile	futile, the District Court order requires 2 levels of appeal for the same LCD twice, 5 for the illegal retroactive liability and 5 for claims on every patient in perpetuity
pre-enforcement challenge	retroactive application of LCD in violation of BIPA 2000
top attorneys & association resources	<i>pro se</i> , solo physician responsible for pro bono medical care & legal help and costs
major business	fragile small business

association PAC	no PAC
many nursing home patients	low incidence, low prevalence, orphan illness needing regional center
no medical turf war	notorious allergy- immunology turf war for decades
voluntary participation	patients have no other insurance option by law
no issue of medical neces- sity	Medicare Act states provider knows what is medically necessary by virtue of their license – CA Medical Board approves & regulates the custom biologicals
Congress could redress Consti- tutional issues including MMA 2003 & BIPA 2000	judicial enforcement only option: denial of fair hearings & multiple violations of 18 US § 1001(a)(1) 18 US § 1001(a)(2) 18 US § 1001(a)(3) 18 US § 1035(a) 18 US § 1505 18 US § 1621

no misconduct	overly constrained interpretation of Medicare review provisions encourages misconduct and gives agency a blank check
DHHS standards are reasonable	CMB approves diagnosis & treatment; DHHS denies either has a medical basis
DHHS: termination is only for the most extreme circumstances	reimbursement terminated 10-31-03 all services on all patients, illegal retroactive liability all services, all patients 2001-2003
no anticompetition	four years of US DOJ ATR oversight because DHHS unduly anticompetitive
shorter & expedited appeal process	denied timely appeals at every level
no DHHS misconduct	AHLA attorney [former CMS Part B attorney] will give US DOJ longstanding examples of DHHS misconduct v. minority opinion allergist-immunologists

no retaliatory State investigations	Dr. Quinn demanded a State investigation based on bogus allegations. The State found NO violations
regulations had been untried & untested	need Court review – 9 years post <i>Shalala v. Illinois Council</i>
nothing required providers to change their behavior immediately	minority allergist would have to switch practice to majority-opinion practice to be reimbursed & abandon this orphan class to no care at all for a treatable hereditary diathesis
associations have no claims	practicing minority allergist will have collateral appeals in perpetuity and never exhaust; only alternative is to abandon patients and leave Medicare

McCarthy v. Madigan

Our class-of two qualifies for relief under all three of the broad circumstances in which the interests of the class weigh heavily against the requirements of exhaustion:

- 1) the unreasonable or indefinite timeframe for administrative action that is causing irreparable harm - preventable premature morbidity and mortality
- 2) the agency is not empowered to adjudicate Constitutional claims and has made no effort to stop this pattern and practice of violations.
- 3) the agency has shown unequivocal bias against our class - refusing to recognize our class' pathophysiological diagnosis, clinical presentation, severity of illness or successful treatment with PF antigens and TF.

Abbott Laboratories v. Gardner

The agency due process violations have a direct adverse effect on the day-to-day practices of all allergist-immunologists whose practices are effectively being socially engineered by DHHS to be cookie cutters. Congress never intended these due process violations to be precluded from timely review. Our class has not been able to submit one claim on even one patient for any service since 10-30-03. If I submitted any Medicare claims since that time, it is clearly legally defined as fraud because I should have known all services haven't been covered based on medical necessity since 10-30-03, the first time there was any change in policy or notice othereof.

The 04-01-04 LCD had the same effect as a substantive rule on all California patients:

Another major exception, of course, is a substantive rule which as a practical matter requires the plaintiff to adjust his conduct immediately. Such agency action is "ripe" for review at once, whether or not explicit statutory review apart from the APA is provided.

Lujan v. National Wildlife Federation citing Abbott Laboratories.

Any submitted claims create years of collateral cases that DHHS illegally demands must be exhausted before any other case can go to judicial review in violation of *Darby v. Cisneros*. Furthermore, MMA 2003, Section 932 requires the Secretary to establish a process to: (1) expedite access to judicial review for legal issues that cannot be resolved administratively and (2) requires expedited review of certain provider agreement determinations, including determinations where termination or certain other immediate remedies are being imposed.

The US Attorney on behalf of DHHS has refused any expedited review in any of our cases. DHHS DAB negligently has allowed the 2nd LCD complaint to go over 14 months without any action after these same appellants already went through the 1st LCD appeal for 20 months and prevailed.

Related Cases

The many comments about the number of cases suggest we need to explain we are not vexatious litigants. Our cases are always the same case – discrimination against our class.

PACER 8:2008cv00633

Under the Employee Retirement Income Security Act of 1974 (ERISA), The Boeing Company contracts for Regence to administrate their medical health plan benefits. Their new medical director, Joe Gifford, M.D. told me he was discontinuing care on one of our families because he was following not only following Medicare but planned to be more restrictive in his medical necessity determinations. Hayley Otto's declaration explains that she needs to continue the custom biologicals. I have asked for a federal question on the Federalism issue - whether ERISA takes determinations of medical necessity away from the states, because all state regulated insurances pay for everything because the CMB approves the diagnosis and regulates the custom biologicals. The alternative is that every Boeing family patient in our class has to file suitin Federal court to access care and no other similarly-situated Boeing families do.

PACER 5:1996cv00219

In 1993, our family moved 12 miles, just yards across the county line. The Cleveland National forest prevented any access to Riverside County schools. There were two problems with the Cali-

fornia statute that ordered that Riverside County shall transfer my children back to their Orange County School (automatic geographic annex area):

- a) MUSD kept the funding for all four children and couldn't be ordered to release it
- b) Orange County couldn't be forced to accept the four children without funding transfer

My son Andy was nine years old at this time. The State Superintendent of School ordered an independent state investigation and recommended a fair hearing before McGeorge School of Law. For a long time, we were subjected to many MUSD frauds.

During the fair hearing, I had to leave and abandon all my rights because the police came to my home on MUSD false charges of the Munchausen's Syndrome by Proxy. There was no way my children could ever sign up for public school again under these circumstances.

All our family's medical records by our top academic physicians were ignored by the County. They had no understanding of our hereditary Th1-Th2 immunoregulatory defect, and just focussed on the symptom "chemical sensitivity" to show MSBP.

My home was raided. My children were taken into "protective custody" unable to see me. Alan S. Levin, M.D., J.D. had written to the Judge predicting Andy would lose 10 lb and get very

sick. Douglas. S. Sandberg, M.D., and all my son's top academic physicians wrote to the Court immediately. All were ignored. Andy was placed in Loma Linda Hospital, where all his care was discontinued including his preservative-free antigen and transfer factor shots. In 12 days in the hospital under CPS care, Andy lost 10 lbs, contracted pneumonia for the first time in 10 years from the brain-dead child in the next bed, had hemoptysis for the first time, and was absolutely terrified. The physicians stated they had no idea what to do and my lawyer arranged for all the children be released home with no conditions.

We restored Andy's medical care and nursed him back over the next many months, while we were fighting these same ongoing MSBP charges. The O.C. Register filed a complaint against me with the CMB. But the CMB knows exactly what I do and has always been extremely complimentary. William Lamb, the top State official assigned to CPS oversight, ordered an investigation and within 48 hours stated they could not believe the conduct of the Child Abuse and Neglect doctor: Claire Sheridan, M.D. That week at one of the endless continuances, the Juvenile Court Judge plopped our docket boxes down in front of him and said to the County Counsel: "I have read this! Is anything in your petition true?" Nothing was true. Not a word.

The case was immediately dismissed. Several major law firms volunteered to file against the

county because another child had recently died in Riverside County protective custody. I was invited to testify before the Riverside Education Grand Jury, because they wanted to indict the MUSD Superintendent. But since the federal case was already filed, they couldn't indict. I said I'd drop the case, but they said once the case is filed, MUSD would demand it proceed. Instead, the State was able to remedy voluntarily making the case unnecessary. The State brought in an investigative team that gave us full immunity from any further CPS actions. The MUSD Superintendent was fired and left with his cronies. The case social worker quit. The county counsel apologized. The detectives and sheriffs were moved to different locations so as not to work with each other again. The records were sealed. The official position of the County is that there never was a case.

Andy's only wish was that he live to be eighteen years old so the government could never take him away again. The only regret I have is that I couldn't give him those last months. He died at seventeen. My children, now adults, placed college on hold the past six years and worked round-the-clock every day without compensation to keep our practice doors open. They do this because they know first-hand what is at stake and how Andy's doctors and home health care pharmacist never abandoned him because we take an oath to our patients.

C O N C L U S I O N

In my humble opinion, those who come to engage in debates of consequence, and who challenge accepted wisdom, should expect to be treated badly. Nonetheless, they must stand undaunted.

Justice Clarence Thomas, American Enterprise Institute 02-13-01

I have had to turn away very sick Medicare patients who I could have helped recover since 2002. They had already failed majority-opinion care. No established Medicare patient was abandoned. This is because I took the 14 years of equity out of my home, my only asset. And I have always chosen a modest living for the past 30 years making what my patients make who are tenured community college teachers working a fraction of their hours. Working from pre-dawn to midnight seven days a week for all these years has barely sustained my solo regional allergy-immunology practice, under the extreme duress of the intensive time resources and costs of the pro bono medical care and legal work on behalf of our established Medicare patients. But I could no more walk away from my patients than I can walk away from this illness, which is encoded in every cell in my body. This is a debate of consequence.

REASONS TO GRANT THE PETITION

There is a practical reason why we employ the presumption not only to questions of whether judicial review is available, but also to questions of when judicial review is available. Delayed review—that is, a requirement that a regulated entity disobey the regulation, suffer an enforcement proceeding by the agency, and only then seek judicial review — may mean no review at all. For when the costs of “presenting” a claim via the delayed review route exceed the costs of simply complying with the regulation, the regulated entity will buckle under and comply, even when the regulation is plainly invalid.

*Justice Clarence Thomas
Shalala v. Illinois Council*

This prescient statement reflects on the real and practical world of DHHS by predicting the inevitability of pay-to play, which NHIC offered us on 11-20-03.

We pray and look up for courage, to the world stage, where this same great man of courage once said:

And from my standpoint, as a black American, it is a high-tech lynching for uppity blacks who in any way deign to think for themselves, to do for themselves, to have different ideas, and it is a message that unless you kowtow to an old order, this is what will happen to you. You will be lynched, destroyed, caricatured by a committee of the U.S. Senate rather than hung from a tree... I am here for my name, my family, my life, and my integrity.

Justice Clarence Thomas.

*Senate Judiciary Committee Hearing
1991*

We are being annihilated by the old order because of who we are genetically, because we deign to think for ourselves, have different ideas and are too uppity to accept pay-to-play. DHHS and NHIC have repeatedly lynched, destroyed and caricatured our class of physicians and patients. To Bruce McDonald, former Deputy Assistant Attorney General, the U.S. Department of Justice AntiTrust Division and Steve Brodsky, our U.S. DOJ attorney, you four years of oversight affirmed truth, justice and the American way. Thanks to you, today we stand undaunted to make these last forty-four steps in our journey to lasting justice. We look to this Court for protection of our integrity and inherent dignity . . equal justice under law.

P R A Y E R F O R R E L I E F

For the foregoing reasons, Petitioners pray that our petition for a writ of certiorari will be granted.

This is signed on this the 12th day of December 2008,
in the city of Laguna Hills under penalty of perjury.

Dorothy Calabrese M.D.

Dorothy Calabrese, M.D.

Pro se

Paul Messer

Paul Messer

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A - 9TH CIRCUIT 08-56278

Docket Entry: 6730996

Filed Dec 08 2008

Molly C Dwyer, Clerk
U.S. Court of Appeals

**UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

Case No. 08-56278
D.C. No. 8:07-cv-01444-CJC
Central District of California,
Santa Ana

PAUL MESSER; et. al.,
Plaintiffs - Appellants

v.

U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES; et al.,
Defendants - Appellees

ORDER

Before:
PREGERSON, MCKEOWN and N.R. SMITH,
Circuit Judges.

Appellants' motions for reconsideration of this court's September 11, 2008 order dismissing this appeal for lack of jurisdiction is denied. This court lacks jurisdiction over this interlocutory.

No motions for reconsideration, rehearing, modification, clarification, stay of the mandate or any other submissions shall be filed or entertained in this closed docket.

MF/Pro Se

Docket Entry: 6730755

Filed Dec 05 2008

Molly C Dwyer, Clerk
U.S. Court of Appeals

**UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

Case No. 08-56358
D.C. No. 8:07-cv-00633-CJC
Central District of California,
Santa Ana

**PAUL MESSER; et. al.,
Plaintiffs - Appellants**
v.
**U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES; et al.,
Defendants - Appellees**

ORDER

Before:
**PREGERSON, MCKEOWN and N.R. SMITH,
Circuit Judges.**

Appellants' motions for reconsideration of this court's September 12, 2008 order dismissing this appeal for lack of jurisdiction is denied. This court lacks jurisdiction over this interlocutory.

No motions for reconsideration, rehearing, modification, clarification, stay of the mandate or any other submissions shall be filed or entertained in this closed docket.

MF/Pro Se

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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION

Case No.: SACV 07-01444-CJC(ANx)

PAUL MESSER and DOROTHY CALABRESE

Plaintiffs, vs.

U.S. DEPT. OF HEALTH AND HUMAN
SERVICES and MICHAEL O. LEAVITT,
SECRETARY, Defendants

**ORDER GRANTING IN PART AND
DENYING IN PART PARTIES' CROSS-
MOTIONS FOR PARTIAL SUMMARY
JUDGMENT**

INTRODUCTION

This case arises out of administrative proceedings before the Centers for Medicare & Medicaid Services ("CMS"), the entity that administers the Medicare program for the Department of Health and Human Services. Plaintiff Paul Messer is a Medicare beneficiary "with a low-incidence, low-prevalence allergic immune disorder that requires custom biologicals." Pls.'s Mem. P. & A. Supp. Mot. Partial Summ. J., pp. 3-4. Plaintiff

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Dorothy Calabrese, M.D., is a Medicare physician "with a regional practice specializing in custom biologicals for these patients with a low-prevalence, low incidence allergic-immune disorder." Id. at p. 4. The Defendants U.S. Department of Health and Human Services ("DHHS") and its Secretary, Michael O. Leavitt (the "Secretary"), contract with private Medicare carriers for the processing and payment of claims for medical care that is provided to aged and disabled persons such as Mr. Messer.

As a Medicare physician provider, Dr. Calabrese has sought reimbursement from Medicare for a type of treatment known as transfer factor immunomodulatory therapy. (Calabrese Decl., March 24, 2008, Ex. 5, DHHS DAB Final Agency Decision, 10/12/06 ("10/12/06 DAB Ruling"), p. 2.) In 2004, the private Medicare carrier National Heritage Insurance Company ("NHIC") ceased covering the cost of transfer factor treatment for Dr. Calabrese's patients. (Id.) In an effort to challenge NHIC's decision, Dr. Calabrese filed a series of administrative appeals as well as three federal actions in this Court.

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In the instant action, Dr. Calabrese alleges that the private Medicare carrier National Heritage Insurance Company ("NHIC") and its medical director, Dr. Bruce Quinn, made false statements and engaged in fraudulent conduct in connection with her claims for coverage of transfer factor treatment. Dr. Calabrese and Mr. Messer allege that DHHS and its Secretary are liable for the alleged misconduct of NHIC and Dr. Quinn and seek injunctive and declaratory relief.

The parties have filed cross-motions for partial summary judgment on two related issues: whether Defendants are protected from liability on Plaintiffs' claims by the defense of sovereign immunity and whether the Court has jurisdiction to hear Plaintiffs' claims. The Court finds that although the Administrative Procedure Act ("APA"), 27 U.S.C. §§ 702 et seq, provides a limited waiver of sovereign immunity in actions for injunctive relief against government agencies, the APA does not allow a litigant to avoid

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the exhaustion requirements of the Medicare Act, 42 U.S.C. § 1395 et seq. Because Plaintiffs have not yet exhausted their administrative claims for benefits, which are inextricably linked to their fraud claims within the federal actions, Plaintiffs cannot demonstrate at this time that Defendants have waived their immunity. After Plaintiffs have fully exhausted their benefits claims, however, Plaintiffs will be able to demonstrate a waiver of immunity pursuant to the APA. At that time, the Court will have jurisdiction over their claims. In the interim, the Court will stay the two pending federal actions to ensure that Plaintiffs' claims are not barred by any applicable statutes of limitations. Accordingly, the parties' cross-motions for partial summary judgment are GRANTED IN PART AND DENIED IN PART.

FACTUAL BACKGROUND

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NHIC is the Medicare Part B contractor for CMS in California, where Dr. Calabrese practices medicine. (10/12/06 DAB Ruling, p. 2.) Dr. Calabrese specializes in the care of patients suffering from a pattern of symptoms known as "multiple chemical sensitivity syndrome." (Id.) As part of her treatment plan, Dr. Calabrese uses custom-prepared transfer factor, an extract derived from dialyzed human leukocytes as part of an immunotherapy regime. (Id.) In 2004, NHIC ceased covering the cost of transfer factor treatment for Dr. Calabrese's Medicare patients. (Id.) In connection with her efforts to receive reimbursement for the transfer factor treatment, Dr. Calabrese filed at least three different complaints with CMS's civil remedies division, resulting in three different administrative proceedings. FN 1

[FN1: Before an action can be filed in a district court, a claimant must proceed through the administrative appeal process for Part B Medicare claims, which involves four levels of administrative review. The four levels of review after the initial determination include (1) a carrier review of the claim; (2) a carrier hearing; (3) a hearing before an administrative law judge; and (4) a review by the Departmental Appeals Board. 42 C.F.R. § 405.801.]

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A. The Administrative Proceedings

The first administrative proceeding arose in connection with NHIC's determination that Dr. Calabrese had been significantly overpaid for submitted claims and therefore she was required to reimburse Medicare. In 2004, NHIC ceased covering the cost of transfer factor treatment for Dr. Calabrese's patients. (10/12/06 DAB Ruling, p. 2.) NHIC sent a letter to Dr. Calabrese on November 19, 2004, stating that NHIC had overpaid her by \$308,311.36 for Medicare claims. (Redacted ALJ Decision issued by Judge Richard B. Gould, dated June 3, 2008, "6/3/08 ALJ Ruling", p. 4.) The letter stated that Dr. Calabrese should not have been paid the outstanding amount because she had not provided adequate medical documentation in support of her claims. (Id.) On December 4, 2004, Dr. Calabrese requested review of the overpayment determination before a hearing officer. On March 28, 2007,² the hearing officer affirmed the overpayment determination, finding that Dr. Calabrese had failed to show medical necessity for the treatment she provided. (Id. at p. 5.)

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The case was appealed to the ALJ Richard Gould, who issued a ruling on June 3, 2008. Judge Gould stated that there were three issues before him: (1) whether transfer factor therapy was a medically recognized and accepted standard of treatment; (2) whether the services Dr. Calabrese provided to her patients on the overpaid claims were medically reasonable and necessary; (3) whether payment was proper under the Social Security Act. (Id. at p. 7.) Judge Gould determined that Dr. Calabrese had failed to provide documentation that adequately demonstrated that the transfer factor treatment she provided was medically reasonable and necessary. (Id. at pp. 32-33.) Therefore, the claims she submitted were not covered by Medicare and the overpayment determination

[FN2] -The long delay between Dr. Calabrese's request for hearing officer review and the hearing officer's ruling is due to the fact that Dr. Calabrese filed a second administrative complaint (to challenge a purported Local Coverage Determination) after requesting review before the hearing officer, and the hearing officer stayed her ruling pending the outcome of the second administrative proceeding. (Id. at p.]

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was proper. (Id.) Judge Gould ruled that Dr. Calabrese was partly to blame for the improper payments because she should have been aware that her record keeping was inadequate and could not justify the submitted claims. (Id. at p. 33.) Finally, Judge Gould found that Dr. Calabrese was financially liable for the amount of overpaid claims.(Id.) Judge Gould's ruling has not yet been appealed to the DAB.

The second administrative proceeding revolved around Dr. Calabrese's challenge to NHIC's non-coverage of transfer factor therapy. On February 8, 2005, Dr. Calabrese filed a complaint with the civil remedies division of CMS pursuant to the provision of the Social Security Act that allows an aggrieved party to challenge a carrier's Local Coverage Determination ("LCD"). (Id.) An LCD is a carrier's local policy regarding whether it will cover a specific treatment. She argued that an article published by Dr. Quinn and NHIC constituted an LCD that NHIC relied on to deny her patients coverage of transfer factor treatment. In response, NHIC argued that it was operating pursuant to a

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National Coverage Determination ("NCD") rather than an LCD. (Id.) The case was appealed all the way to the Departmental Appeals Board ("DAB"), the highest level of administrative review, and the primary issue before the DAB was whether NHIC has in fact established and maintained a carrier-wide LCD barring coverage of transfer factor treatment. (Id. at p. 5.)

The DAB ruled that the challenged article was in fact an LCD but that, because NHIC had already withdrawn the article, the issue was moot and Dr. Calabrese's complaint should be dismissed. (Id. at pp. 6, 17.) The DAB also addressed Dr. Calabrese's claims that Dr. Quinn and NHIC had engaged in misconduct and fraud. Specifically, she alleged that Dr. Quinn had misled the ALJ by suggesting that the article containing the supposed LCD addressed only coding rather than coverage policy. (Id. at p. 8, n. 11.) She alleged that NHIC would continue to operate under a policy of denying all coverage of transfer factor treatment, whether or not it had issued a formal LCD.

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(Id. at p. 14.) The DAB rejected both of these arguments, finding that the record did not contain any evidence of "fraud" or a "cover-up" by Dr. Quinn and that there was no reason to believe that NHIC would continue to use the challenged article as a "secret LCD." (Id. at pp. 8, n. 11, 14.)

Dr. Calabrese filed her third administrative complaint on January 14, 2008, when she filed a joint challenge with Medicare beneficiary Marilyn Clark-Koeing to the LCD L26134, "Homeopathic Medicine and Transfer Factor." The challenged LCD provides that transfer factor therapy is not medically reasonable and necessary, and it was used to deny Dr. Calabrese coverage for services performed on or after October 28, 2007. This complaint is presently pending before the DAB.

B. The Federal Actions

In addition to the three administrative proceedings, Dr. Calabrese has filed three

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different complaints in this Court. Plaintiffs Dr. Calabrese and Paul Messer filed the first case, Dorothy Calabrese, et al. v. Michael O. Leavitt, Secretary, et al., Case No. SACV 06-1217 CJC (RNBx) (the "First Federal Action"), on December 15, 2006. The First Federal Action alleged that defendants Michael O. Leavitt, the Secretary of the Department of Health and Human Services, Daniel Schreiner, the CMS Ombudsman, National Heritage Insurance Company ("NHIC"), Electronic Data Systems, Inc., Charity Horton, an NHIC hearing officer, Dr. Bruce Quinn, NHIC's Medical Director, and Carlos Rivera, NHIC's Medical Review Manager, wrongfully denied claims for reimbursement of transfer factor therapy for individual beneficiaries on the grounds that the treatment was not reasonable and medically necessary, in violation of various criminal and civil federal statutes. Plaintiffs brought claims against Defendants for false statements under 18 U.S.C. § 1001(a)(1), obstruction of justice under 18 U.S.C. § 1505, breach of fiduciary duty under 29 U.S.C. § 1109(a), Medicare violation of 42 U.S.C. § 1395, Freedom of

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Information Act violations of 5 U.S.C. § 552(A)(2), and violations of the Fourteenth Amendment.

On September 19, 2007, the Court dismissed the First Federal Action with prejudice, finding that the Court lacked subject matter jurisdiction over the claims because Plaintiffs had failed to exhaust their administrative remedies prior to filing suit and that Defendants were protected from liability by the doctrine of sovereign immunity.

On December 14, 2007, Plaintiffs Dr. Calabrese and Paul Messer filed the instant action, Case No. SACV 07-1444 CJC (RNBx) (the "Second Federal Action"). The Second Federal Action alleges that Dr. Quinn and NHIC engaged in fraud and other misconduct during the CMS administrative appeals process, described infra, Part C. Under the first cause of action, Plaintiffs allege that NHIC and Dr. Quinn, while acting "in the course of their official duties," knowingly and willfully concealed material facts

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and made false entries to the DHHS Office of Medicare Hearings and Appeals ("OMHA"). SAC, ¶ 15. Plaintiffs allege that this conduct constitutes fraud and gross negligence and that it violates the Medicare Drug, Improvement and Modernization Act of 2003 ("MMA"), 42 U.S.C. 1395kk-1(d)(3), which amended the Medicare Act. Id. at ¶¶ 18-19. The second cause of action alleges that Dr. Quinn and NHIC made false statements to the OMHA in violation of Medicare regulations and the MMA. Id. at ¶¶ 21-22. The third cause of action asserts that Dr. Quinn and NHIC submitted false documents to the OMHA, in violation of the MMA and Medicare regulations. Id. at ¶¶ 24-26. The fourth cause of action alleges that Dr. Quinn made false statements to the NHIC Carrier Advisory Committee in violation of the MMA, the Medicare Program Integrity Manual Chapter 13, and BIPA 2000 Section 522. Id. at ¶¶ 28. The fifth cause of action alleges that Dr. Quinn made false statements regarding Dr. Calabrese and transfer factor therapy to the American Academy of Allergy Asthma and Immunology, in violation of 18 U.S.C. § 1035 and the MMA. Id. at ¶ 28. The sixth cause of action alleges that Dr.

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Quinn and NHIC obstructed justice in violation of 18 U.S.C. § 1505 and the MMA. Id. At ¶ 31. The seventh cause of action alleges that Dr. Quinn and NHIC interfered with Dr. Calabrese's allergy-immunology practice and adversely affected her ability to properly care for her patients in violation of 42 U.S.C. § 1395.

The Second Federal Action seeks injunctive and declaratory relief rather than damages. Plaintiffs request the following: (1) that the Court review the contractual, statutory, and policy violations alleged; (2) that the Court refer Dr. Quinn to the Department of Justice for an investigation; (3) that the Court review all of the relevant DHHS policies and regulations, the relevant contracts between DHHS and its carriers, and the relevant Medicare laws, including the Benefits Improvement and Protection Act of 2000; (4) that the Court incorporate the rulings of Judge Gould from the December 19, 2007 hearing into the record; (5) that the Court grant "appropriate injunctive and declaratory relief after judicial review as this Court shall find just and proper to remedy

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the violations and restore the rule of law"; and (6) that the Court grant Plaintiff their litigations costs and attorneys' fees. SAC, ¶¶ 37-39.

On June 9, 2008, Plaintiffs Dr. Calabrese and Paul Messer filed a third case in this Court, Case No. SACV 08-633 CJC (RNBx) (the "Third Federal Action"). The Third Federal Action names as defendants DHHS; Michael O. Leavitt, DHHS's Secretary; Leslie Norwalk, the acting administrator of CMS; Judge Perry Rhew, the Chief ALJ of OMHA; and Judge Ellen Koldewey, the ALJ of the Western Division of OMHA. Plaintiffs allege that Judge Koldewey signed Judge Gould's name to the June 3, 2008 ALJ Ruling without any legal authority to do so.³ Compl., ¶ 3. Plaintiffs allege that Judge Gould never would have signed the 6/3/08 ALJ Ruling "because it completely misstates the evidence and contradicts the law." Id. at ¶ 33. Plaintiffs allege that Judge [FN3]

[FN3] The signature page of the 6/3/08 ALJ Ruling states in handwritten script: "Richard B. Gould [illegible] by EM Koldeway MALJ." 6/3/08 ALJ Ruling, p. 33.

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Koldeway's conduct violates the Due Process clause of the Fifth Amendment, the MMA and 42 U.S.C. § 1983. Id. at ¶¶ 58, 63, 65. They further allege that Judge Koldewey obstructed justice in violation of 18 U.S.C. § 1505. Id. at ¶ 61. Plaintiffs seek injunctive and declaratory relief, including an order that Judge Gould's name be removed from the June 3, 2008 ALJ Ruling, that Judge Koldewey be referred to the California Bar Association for investigation, and that Plaintiffs be awarded their attorneys' fees and costs. Id. at ¶ 67.

LEGAL STANDARD

Summary judgment is proper if the evidence before the court "show[s] that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." FED. R. CIV. P. 56(c); see also Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). A factual issue is "genuine" when there is sufficient evidence such that a

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reasonable trier of fact could resolve the issue in the non-movant's favor, and an issue is "material" when its resolution might affect the outcome of the suit under the governing law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The moving party bears the initial burden of demonstrating that there are no genuine material issues, and that it is entitled to judgment as a matter of law. *T.W. Elec. Serv., Inc. v. Pac. Elec. Contractors Ass'n*, 809 F.2d 626, 630-31 (9th Cir. 1987). Once this burden has been met, the party resisting the motion "must set forth specific facts showing that there is a genuine issue for trial." *Anderson*, 477 U.S. at 256. In considering a motion for summary judgment, the court must examine all the evidence in the light most favorable to the non moving party. *United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962). The court does not make credibility determinations, nor does it weigh conflicting evidence. *Eastman Kodak Co. v. Image Tech. Servs., Inc.*, 504 U.S. 451, 456 (1992).

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ANALYSIS

A. WHETHER PLAINTIFFS' HAVE DEMONSTRATED A WAIVER OF SOVEREIGN IMMUNITY

"The United States, including its agencies and employees, can be sued only to the extent that it has expressly waived its sovereign immunity." *Kaiser v. Blue Cross of California, et al.*, 347 F.3d 1107, 1117 (9th Cir. 2003) (citing *United States v. Testan*, 424 U.S. 392, 399 (1976)). Absent a waiver of sovereign immunity, courts have no subject matter jurisdiction over cases against the government. *United States v. Mitchell*, 463 U.S. 206, 212 (1983). It is well settled that the plaintiff has the burden of showing an unequivocal waiver of sovereign immunity. *Baker v. United States*, 817 F.2d 560, 562 (9th Cir. 1987). Waiver of sovereign immunity is to be strictly construed. *United States v. Nordic Village, Inc.*, 503 U.S. 30, 33-34 (1992).

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Plaintiffs argue that Defendants have waived their immunity pursuant to the APA, which provides, in relevant part:

A person suffering a legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof. 5 U.S.C. § 702 (West 2008).

The APA waives sovereign immunity only if three conditions are met: (1) Plaintiffs' APA claims are for relief "other than money damages"; (2) an adequate remedy for Plaintiffs' APA claims is not available elsewhere; and (3) Plaintiffs' APA claims do not seek relief expressly or impliedly forbidden by another statute. Tucson Airport Auth. V. General Dynamics Corp., 136 F.3d 641, 645 (9th Cir. 1998). In addition to these threshold requirements, a litigant bringing suit pursuant to the APA must demonstrate that the interest she seeks to protect is "arguably within the zone of interests to be protected or regulated by the statute or constitutional guarantee in question." Clarke v. Securities Industry Association, 479 U.S. 388, 395-96 (1970).

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Assuming without deciding that Plaintiffs can meet these threshold requirements to have standing under the APA, Defendants argue that Plaintiffs are also required to meet the jurisdictional requirements of the Medicare Act. Specifically, Defendants assert that there can be no jurisdiction under the APA for claims arising under the Medicare Act unless Plaintiffs have exhausted their administrative remedies, as required by 42 U.S.C. § 405 (g). Defendants are correct. As the Supreme Court held in *Califano v. Sanders*, the APA does not provide an independent grant of subject matter jurisdiction that allows a federal court to review a decision of DHHS, when the Social Security Act would not permit such review. 430 U.S. 99, 107-108 (1977). In *Heckler v. Ringer*, the Court came to the same conclusion in the context of claims arising under the Medicare Act. The Court held that when a claim arises under the Medicare Act, the Medicare Act's exhaustion requirements preclude both federal question jurisdiction and jurisdiction under the APA. 466 U.S. 602, 622 (1984). Accordingly, if Plaintiffs' claims arise under

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the Medicare Act, they cannot demonstrate that Defendants have waived their sovereign immunity unless and until they have exhausted their administrative remedies.**[FN4]**

[FN4] On April 1, 2008, the Court issued an order ruling that Plaintiffs had exhausted the claims of the Second Federal Action. While that was indeed the Court's understanding at the time it issued the order, the Court now, due to briefing specifically requested by the Court on the issue of sovereign immunity, has sufficient information in the record before it to conclude otherwise

B. WHETHER PLAINTIFFS CLAIMS ARISE UNDER THE MEDICARE ACT

The Supreme Court has applied two tests to determine whether claims "arise under" Medicare. First, claims that are "inextricably intertwined" with a Medicare benefits determination may arise under Medicare. See *Heckler v. Ringer*, 466 U.S. 602, 614 (1984). Second, "claims in which 'both the standing and the substantive basis for the presentation' of the claims" is the Medicare Act may arise under Medicare. *Id.* at 615

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(quoting Weinberger v. Salfi, 422 U.S. 749, 760-61 (1975)). Applying either test, the Plaintiffs' claims "arise under" the Medicare Act.

Applying the first test to the Second Federal Action,[FN 5} the question is whether Plaintiffs' claims that Dr. Quinn engaged in fraud and made false statements before the OMHA, the Carrier Advisory Committee and the AAAAI are "inextricably linked" to Plaintiffs' administrative claims for benefits. In answering this question, the Supreme Court's ruling in Ringer is instructive.

In that case, the plaintiffs were Medicare claimants who had undergone a surgical procedure known as bilateral carotid body resection ("BCBR"), but who were refused reimbursement for the procedure based on the Secretary's ruling that the BCBR treatment was not medically "reasonable and necessary" within the meaning of the Medicare Act. 466 U.S. at 605. Although the plaintiffs had not yet exhausted their administrative remedies under the Medicare Act, they filed suit in federal court to challenge the Secretary's ruling. Id. Rather than styling

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their suit as a claim for benefits, the plaintiffs alleged that the Secretary's ruling violated the Due Process Clause of the Fifth Amendment, the APA, and Medicare regulations. Plaintiffs sought injunctive and declaratory relief rather than monetary damages. *Id.* at 614

The Supreme Court concluded that the plaintiffs' claims were "at bottom, a claim that they should be paid for their BCBR surgery." *Id.* The Supreme Court acknowledged that the plaintiffs were technically objecting to the Secretary's procedure and her failure to comply with the requirements of the APA, rather than directly seeking benefits, but nonetheless concluded that these claims were "inextricably intertwined" with their claims for benefits. *Id.* The Supreme Court reasoned that in seeking a declaration that the expenses of the BCBR surgery were reimbursable under the Medicare Act, the plaintiffs

[FN5] In order to determine whether Plaintiffs' claims "arise under" the Medicare Act, the Court will consider the Second and Third Federal Actions separately.

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were essentially seeking actual benefits. It made no difference whether the plaintiffs' claims were labeled as procedural or substantive, or whether they sought declaratory or monetary relief; all claims that were inextricably linked to a claim for benefits "arose under" the Medicare Act and had to be exhausted prior to a finding of federal jurisdiction. *Id.* at 614-615. [FN6]

Like the plaintiffs in Ringer, Dr. Calabrese and Mr. Messer are seeking the equivalent of a declaration that they are entitled to coverage of a specific treatment, or at the very least that they are entitled to a new determination of their claims for coverage of a specific treatment. Plaintiffs allege that Dr. Quinn's fraudulent acts and false statements during the Medicare appeals process have caused "irreparable harm" to Dr. Calabrese's patients because they can no longer receive Medicare coverage for transfer factor treatment. SAC, ¶ 1. In order to alleviate their harm, Plaintiffs demand that the Court refer Dr. Quinn to the Department of Justice for a criminal investigation, review all

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applicable Medicare regulations, carrier contracts, DHHS policies, and ultimately, "restore the rule of law." Plaintiffs' prayer for relief is tantamount to a request that the Court find that NHIC's decision to deny coverage for transfer factor treatment was so tainted by fraud that the ruling should be vacated, with instructions to NHIC to either begin the claims determination process anew or to immediately award benefits for transfer factor treatment. Were the Court to award such relief, it would clearly be ruling that Plaintiffs are entitled to benefits or to a new determination of benefits, not just making a finding regarding fraud. Thus, although Plaintiffs are technically objecting to the process by which they were denied benefits, as did the plaintiffs in Ringer, their

[FN6]The Ringer court also held that one of the plaintiffs who had not yet undergone the BCBR surgery, but sought to challenge the Secretary's ruling on the grounds that he hoped to have the surgery performed and reimbursed, was also subject to the exhaustion requirements. 466 U.S. at 620. The Court held that when a plaintiff is not seeking immediate benefits, but a right to future benefits, his claim must still be construed as one "arising under" the Medicare Act. Id. at 621.

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federal claims for declaratory relief cannot be separated from their administrative claims for benefits.

The Ninth Circuit's ruling in *Kaiser v. Blue Cross of California* further supports the conclusion that the claims of the Second Federal Action "arise under" the Medicare Act. In *Kaiser*, a home health agency that was a certified Medicare provider was forced to enter bankruptcy after the Medicare carrier ceased payment on the agency's claims due to a prior overpayment. 347 F.3d 1107, 1110 (9th Cir. 2003). The agency sued the carrier and DHHS for violations of the APA, the Fifth Amendment, and various Medicare regulations, among others. *Id.* at 1111. Applying the "inextricably linked" test from *Ringer*, the court found that all of the challenged conduct by the carrier (the failure to follow Medicare regulations that called for proper notice and an opportunity to enter into a repayment plan prior to ceasing payment) pertained to the appropriateness of the defendants' decisions regarding compensation for Medicare claims. *Id.* at 1114-1115.

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The court pointed out that "had the [plaintiffs] been immediately granted a satisfactory [repayment plan], for example, or had they never accrued an overpayment in the first place, they never would have brought this case. Hearing most of the [plaintiffs'] claims would necessarily mean redeciding Blue Cross' CCH-related Medicare decisions." Id. At 1115. Based on this reasoning, the court concluded that these claims arose under Medicare and were subject to the exhaustion requirements of 42 U.S.C. § 405(h). Id.

Like the plaintiffs in Kaiser, Dr. Calabrese and Mr. Messer allege that a carrier's misconduct in connection with an overpayment determination violates the APA, Medicare regulations, and various other statutes. Yet all of the challenged conduct (Dr. Quinn's statements regarding transfer factor therapy to the OMHA, the Carrier Advisory Committee, and the AAAAI) pertains to the appropriateness of NHIC's decisions regarding compensation for Medicare claims for transfer factor treatment. Just as the court reasoned on Kaiser, "[h]ad the [plaintiffs] never accrued an overpayment in the first

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place, they never would have brought this case." Id. at 1115. "Hearing most of the [plaintiffs'] claims would necessarily mean redeciding [NHIC's] CCH-related Medicare decisions." Id. In short, were the Court to grant Plaintiffs' request for injunctive and declaratory relief, it would necessarily have to review NHIC's decisions regarding the appropriateness of compensation for transfer factor therapy. Accordingly, the Second Federal Action is, in essence, seeking to recover benefits.

The claims of the Second Federal Action also "arise under" the Medicare Act under the second test articulated by the Supreme Court in Ringer, which provides that when "both the standing and the substantive basis for the presentation of the claims" is the Medicare Act, the claims may arise under Medicare. Id. at 615. The Medicare Act is the substantive basis for Plaintiffs' claims, as evidenced by the fact that they must rely in a dispositive manner on the standards of the Medicare Act and NHIC's contract with the Secretary. The underlying claim of fraud would necessitate a showing that Dr. Quinn and

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NHIC violated a duty owed to Plaintiffs, and that the Medicare Act and regulations define the scope of that duty. See Bodimetric Health Services, Inc. v. Aetna Life & Casualty, 706 F. Supp. 619, 626 (N.D. Ill. 1989) (using similar logic to evaluate whether a civil RICO claim arose under the Medicare Act). Plaintiffs also must rely on the Medicare Act in order to establish the injury required by the standing doctrine, i.e. that they were denied an entitlement owed to them under the Act. See *id.*

Turning to the Third Federal Action, Plaintiffs' claims can be boiled down to the following contention: Judge Koldeway obstructed justice and violated Plaintiffs' due process rights by wrongfully signing Judge Gould's name on the June 3, 2008 ALJ Ruling. Because Plaintiffs' alleged harm from the fraud in the signature is inextricably linked to the June 3, 2008 ruling denying Plaintiffs' benefits, the claims of the Third Federal Action "arise under" the Medicare Act. As discussed, the issues before Judge Gould were: (1) whether transfer factor treatment is medically reasonable and necessary;

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and (2) whether the prior payments to Dr. Calabrese for transfer factor treatment were improper. Judge Koldewey, on behalf of Judge Gould, ruled that the over-payment determination was proper and that transfer factor treatment was not medically reasonable and necessary. Plaintiffs allege that Judge Gould would never have made such a decision. See Compl., ¶ 29 ("Dr. Calabrese knew for certain that Judge Richard B. Gould would never be a party to it. The decision is 180 degrees the opposite of what Judge Richard B. Gould would have written."); see id. at ¶ 33 ("Judge Richard B. Gould would never have signed the decision because it completely misstates the evidence and contradicts the law.") These allegations demonstrate that Plaintiffs are asserting that there is a causal relationship between the fraud and the negative benefits ruling, i.e. that they would have received a positive ruling on their benefits claim if Judge Gould had prepared and signed the ruling instead of Judge Koldeway. It follows that if the Court were to try to evaluate Plaintiffs' fraud claims, the Court also would have to decide whether Plaintiffs should have received a ruling providing coverage of transfer factor

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treatment. The Court would need to evaluate Plaintiffs' arguments that transfer factor therapy is medically reasonable and necessary and that NHIC's over-payment determination was erroneous. Clearly, the claims of the Third Federal Action are inextricably linked to a claim for benefits.

Applying the second test from Ringer[FN7] to the claims of the Third Federal Action, the Court also concludes that the claims "arise under" the Medicare Act. In order to support their argument that Judge Koldewey's fraud resulted in a negative benefits ruling, Plaintiffs have to prove that Judge Gould would have ruled that Plaintiffs are entitled to coverage of transfer factor treatment. To make this showing, Plaintiffs would have to rely on the standards of the Medicare Act to demonstrate that transfer factor treatment is

[FN7] The second test from Ringer provides that when "both the standing and the substantive basis for the presentation of the claims" is the Medicare Act, the claims may "arise under" the Medicare Act. 466 U.S. at 615.

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medically reasonable and necessary. Such reliance shows that the Medicare Act provides the substantive basis for the presentation of Plaintiffs' claims. The Medicare Act also provides the standing for the presentation of the claims because Plaintiffs must rely on the Act to establish that they were harmed when NHIC denied them an entitlement owed to them under the Act.

Plaintiffs have argued at various points during these proceedings that they should be exempt from the exhaustion requirements of the Medicare Act because they allege fraud and criminal violations rather than mere violations of the Medicare Act. See Pls.' Opp'n Mot. Dismiss, ¶ 21. Plaintiffs' argument is based on a misunderstanding of the law. If Plaintiffs' claims of fraud are inextricably linked to a claim for benefits, they must exhaust their remedies before seeking relief in federal court, just as they would with any other type of claim. See Bodimetric Health Services, Inc. v. Aetna Life & Casualty, 903 F.2d 480 (7th Cir. 1990). In Bodimetric, like in Kaiser, a home health agency that

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provided Medicare services was forced to shut down after the Medicare carrier refused to reimburse the agency for certain of its claims. *Id.* at 481. The agency, Bodimetric, brought numerous claims against the carrier, including claims for fraud and violations of the civil RICO statute. *Id.* at 483. Despite the fraud allegations, the court found that "Bodimetric's grievance [was], at bottom, a challenge to [the carrier's] approach to processing claims," and thus their fraud claims were inextricably linked with their claims for benefits. *Id.* at 486-487. Accordingly, the claims arose under the Medicare Act and Bodimetric was required to exhaust its administrative remedies before seeking judicial review. *Id.* at 487.

Here too, Plaintiffs cannot escape the exhaustion requirement by styling their claims as allegations of fraud. Because the claims of the Second and Third Federal Actions are "inextricably linked" to claims for coverage of transfer factor treatment, the claims "arise under" the Medicare Act.

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C. WHETHER PLAINTIFFS HAVE EXHAUSTED THEIR ADMINISTRATIVE REMEDIES

Given that Plaintiffs claims arise under the Medicare Act, the next inquiry is whether they have fulfilled the exhaustion requirement. 42 U.S.C. § 1395ff(b)(1)(A) governs the judicial review of claims arising under Part B of the Medicare Act, such as the claims asserted by Plaintiffs. § 1395ff(b)(1)(A) provides in relevant part:

[a]ny individual dissatisfied with any initial determination under subsection (a)(1) shall be entitled to reconsideration of the determination, and subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title. [FN8]

This section establishes that a claimant may seek judicial review of a Secretary's final decision, but only in accordance with 42 U.S.C. § 405(g). 42 U.S.C. § 405(h) further clarifies this point, providing that "[n]o findings of fact or decision of the

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Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 29 to recover on any claim arising under this subchapter." The Ninth Circuit has held that the phrase "except as herein provided" refers to § 405(g), which permits an individual to obtain judicial review of a "final decision" of the Secretary. *Hironymous v. Bowen*, 800 F.2d 888, 892 (9th Cir. 1986). The court held that when a plaintiff is seeking substantive review of a decision of the Secretary, the review procedure under section 405(g) "is...the exclusive avenue for reviewing [the plaintiff's] claim. Because it is exclusive, unless it is exhausted, jurisdiction under the Mandamus Act is unavailable." Id.

[FN8] Section 405(g) provides in part, "Any individual, after any final decision of the Commissioner of the Social Security made after a hearing to which he was a party..., may obtain a review of such decision by a civil action..."

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In order to obtain a "final decision" of the Secretary, a claimant must proceed through the administrative appeal process for Part B Medicare claims, which involves four levels of administrative review after a carrier's initial benefits determination. See 42 CFR 405.801, 405.857(a). If a beneficiary is dissatisfied with the initial determination, he may request a carrier review of the claim. 42 C.F.R. § 405.801. Following the carrier's review, the beneficiary may request a carrier hearing if the amount in controversy is at least \$100. Id. Following the carrier hearing, the beneficiary may obtain a hearing before an Administrative Law Judge ("ALJ") if the amount in controversy is at least \$500. Id. If the beneficiary is dissatisfied with the decision of the ALJ, he may request the Departmental Appeals Board ("DAB") to review the case. Id. Only after this administrative process is exhausted may a claimant seek judicial review in federal district court of the Secretary's "final decision" on the claim, as provided in 42 U.S.C. § 405(g). Id.

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Here, there are at least two proceedings for which Plaintiffs have not yet received a "final decision" from the Secretary. First, they have not yet received a DAB review on the 6/3/08 ALJ Ruling that transfer factor therapy is not medically reasonable and necessary and that the prior payments to Dr. Calabrese for transfer factor treatment were improper. Second, Dr. Calabrese challenge to the LCD L26134, "Homeopathic Medicine and Transfer Factor," is currently pending before the DAB. These two pending proceedings are clearly claims for benefits, in that Plaintiffs are challenging a ruling that they improperly received benefits as well as the underlying policy that may be used to deny them future benefits for transfer factor treatment.

Although Plaintiffs are not required to raise their allegations of fraud in Judge Gould's signature before the DAB for purposes of exhaustion, the Court strongly encourages Plaintiffs to do so. If Plaintiffs raise their allegations of fraud by Judge Koldewey before the DAB and the DAB addresses those contentions, the Court will have

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a much more complete record on which to rule on the claims of the Third Federal Action. Because there is no dispute that Plaintiffs have not yet exhausted their claims for benefits, which are inextricably linked to the claims of the Second and Third Federal Actions, the Court now stays all proceedings in connection with the Second and Third Federal Actions. [FN9] Plaintiffs may move to lift the stay once the Secretary issues a final decision on their administrative claims.

The Court recognizes from Plaintiffs' pleadings that they are frustrated with the judicial and administrative process, based on their assertion that "six years is too long" to wait for relief on their claims. Pls.' Mem. P. & A. Supp. Mot. Partial Summ. J., p. 3. While the Court has no authority to hear Plaintiffs' claims at the present time, the Court hopes that Plaintiffs will take solace in the Court's firm belief that it will have jurisdiction over all of their claims, for both benefits and fraud, once Plaintiffs have completed the process of exhaustion. The defense of sovereign immunity should not be a

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claims if their claims are properly exhausted.

D. PLAINTIFFS' ALTERNATIVE ARGUMENTS FOR WAIVER OF SOVEREIGN IMMUNITY

Plaintiffs make three other arguments in support of their motion for partial summary judgment, none of which demonstrates that Defendants have waived their sovereign immunity. Plaintiffs rely primarily on the case *Willowbrook v. Olech*, 528 U.S. 562 (2000) as a basis for a waiver of sovereign immunity. See Mem. P. & A., pp. 405. *Willowbrook* does not address the issue of sovereign immunity at any point in the opinion. Instead, it involves the question of whether the Equal Protection Clause gives rise to a cause of action on behalf of a "class of one" where the plaintiff did not allege

[FN9] The Court will stay the Second and Third Federal Actions rather than dismiss them without prejudice to avoid the possibility that Plaintiffs' claims will be barred by applicable statutes of limitations.

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membership in a class or group. 528 U.S. at 564. Accordingly, Plaintiffs' reliance on Willowbrook is misplaced. Plaintiffs also reference the case *Bowen v. Georgetown University Hospital* in their brief in support of partial summary judgment. *Bowen* is inapplicable to this case for two reasons. First, it was undisputed that the claimants in *Bowen* had exhausted their administrative remedies prior to seeking judicial review in federal court, unlike Plaintiffs in the instant case. 488 U.S. 204, 207 (1988). Second, *Bowen* involved a purely legal challenge to the validity of a regulation promulgated by DHHS rather than a claim for Medicare reimbursement. Here, Plaintiffs do not allege in either the Second or Third Federal Action that they are challenging the validity of the Medicare regulations used to deny them benefits for transfer factor treatment. Instead, Plaintiffs allege in the Second Federal Action that Dr. Quinn and NHIC violated various Medicare regulations and criminal statutes in connection with Plaintiffs' claims for benefits. Likewise, in the Third

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Federal Action, Plaintiffs allege that Judge Koldeway's conduct violated their due process rights as well as criminal statutes, but they do not seek to challenge the validity of any administrative regulation. Because Plaintiffs are challenging the amount of benefits awarded (and conduct that occurred in connection with the amount determination) rather than the legality of any applicable regulation, their claims are not cognizable under Bowen and do not provide an exception to the exhaustion requirements of the Medicare Act.

Plaintiffs have previously cited the decision in *Bowen v. Michigan Academy of Family Physicians* as a basis for an exception to the exhaustion requirement. In *Michigan Academy*, a group of physicians challenged a Medicare regulation that authorized the payment of benefits in different amounts for similar physicians' services on both constitutional and statutory grounds. 476 U.S. 667, 668 (1986). At the time the plaintiffs' claims arose, section 1395ff of the Medicare Act did not allow for judicial

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review of Medicare Part B determinations. Id. at 675. The Supreme Court concluded that section 1395ff of the Medicare Act did not bar judicial review of challenges to the validity of administrative regulations promulgated under the Medicare Act, but that it only barred review of determinations regarding the amount of benefits awarded. Id. At 675-76. Based on this reasoning, the Supreme Court ruled that the federal court had jurisdiction over the plaintiffs' claims.

In *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 120 S.Ct. 1084, 146 L.Ed.2d 1 (2000), the Supreme Court clarified and limited the holding of Michigan Academy, stating that it stands for the proposition that "§ 1395ii does not apply § 405(h) where application of § 405(h) would not simply channel review through the agency, but would mean no review at all." Based on this narrow reading of Bowen, Plaintiffs can only escape the exhaustion requirement if they can demonstrate that completing the review process would mean no judicial review at all. Plaintiffs have failed to make this

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showing. The claims within the First and Second Federal Actions are moving through the Medicare administrative process. Once plaintiffs have exhausted those claims, the Court will be able to exercise jurisdiction over them. Because the exhaustion requirement as applied to this case does not deprive Plaintiffs of any review whatsoever, Michigan Academy provides no basis for a waiver of sovereign immunity.

CONCLUSION

Because Plaintiffs have not yet exhausted their claims for benefits, which are inextricably linked to the claims of the Second and Third Federal Actions, Plaintiffs cannot at this time demonstrate that Defendants have waived their sovereign immunity pursuant to the APA. The Court encourages Plaintiffs to complete the administrative process so that the Court has jurisdiction to hear their claims. Pending exhaustion, the Court now stays all proceedings in connection with the Second Federal Action, Case No.

C - SACV 07-01444 STAY 23

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SACV 07-1444 CJC (ANx), and the Third Federal Action, Case No. SACV 08-633 CJC (RNBx).

DATED: July 25, 2008



CORMAC L. GARNEY

UNITED STATES DISTRICT JUDGE

D - SACV 08-00663 STAY

**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
CIVIL MINUTES - GENERAL**

Case No. SACV 08-00633-CJC(RNBx)

Date: July 25, 2008

Title: PAUL MESSER, ET AL. V. U.S. DEPT.
OF HEALTH AND HUMAN SERVICES, ET
AL.

Present: HONORABLE CORMAC J. CARNEY,
UNITED STATES DISTRICT JUDGE

Michelle Uriel Deputy Clerk Present

Court Reporter Present

Attorneys Present for Plaintiff: None

Attorneys Present for Defendant: None Present

**PROCEEDINGS: (IN CHAMBERS) ORDER
STAYING CASE**

Pursuant to the Court's order in Case No. SACV 07-1444, Granting in Part and Denying in Part Parties' Cross-Motions for Partial Summary Judgment, dated July 25, 2008, the Court now stays all proceedings in connection with Case No. SACV 08-633. Plaintiffs may move to lift the stay once they have exhausted their administrative claims for benefits before the Centers for Medicare & Medicaid Services of the Department of Health and Human Services.

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**E - S A C V 0 7 - 0 1 4 4 4 G R A N T I N G
E X H A U S T I O N**

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
CIVIL MINUTES - GENERAL

Case No. SACV 07-01444-CJC(ANx)

Date: April 1, 2008

Title: DOROTHY CALABRESE, et al. v.
MICHAEL O. LEAVITT, SECRETARY, et al.

PRESENT:

HONORABLE CORMAC J. CARNEY, UNITED
STATES DISTRICT JUDGE

Michelle Uriel

Deputy Clerk

Court Reporter

Present

ATTORNEYS PRESENT FOR PLAINTIFF:
None

ATTORNEYS PRESENT FOR DEFENDANT:
None Present

PROCEEDINGS: (IN CHAMBERS) ORDER
DENYING DEFENDANTS'

MOTION TO DISMISS [filed 3/10/08]

Defendants' motion to dismiss Plaintiffs' Second
Amended Complaint ("SAC") is DENIED.

**E - S A C V 0 7 - 0 1 4 4 4 G R A N T I N G
E X H A U S T I O N**

The SAC alleges misconduct by the carrier known as the National Heritage Insurance Company ("NHIC") and by Dr. Bruce Quinn, NHIC's Medical Director.

Plaintiffs exhausted these claims of misconduct before the Civil Remedies Division of Health and Human Services' Departmental Appeals Board ("DAB") on October 12, 2006, when the DAB rejected those claims. The Court recognizes that Defendants may have other legal defenses, such as governmental immunity and privilege, to Plaintiffs' misconduct claims, but any such defenses must be resolved by way of a motion for summary judgment.

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F - U . S . D O J C I V I L R I G H T S

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Donald Walker
U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, N.W.
Complaint Adjudication Office, NALC
Washington, D.C. 20530

Dear Mr. Walker:

I was advised to file a formal complaint with your office regarding the conduct of the US Attorney in this case. Enclosed is the Petition for a Writ of Certiorari in the Supreme Court of the United States which is our most current filing.

1. On 12-17-07, we had an Office of Medicare Hearings and Appeals [hereinafter OMHA] hearing before the Honorable Richard B. Gould. Post hearing briefing was done through the middle of March, because the Medicare contractor attorney, John A. Conkle, was out of the country.

F - U. S. D O J C I V I L R I G H T S

2. When I received the Contractor post hearing brief it included documents that Judge Gould had refused to enter into the court docket. I contacted the OMHA and was literally told, that they were in charge now. My first thought was: "What happened to Judge Gould?" I was naïve enough to think that by law, OMHA would have to tell me if Judge Gould was gone.

3. On 03-31-08, Federal District Court Judge Cormac J. Carney asked Russell Chittenden, the U.S. Attorney, to find out when Judge Gould would be issuing his final decision. Instead of a simple phone call to Judge Gould's staff, the US Attorney in conjunction with the DHHS CMS wrote an odd letter stating Judge Gould would have to report directly to them, and then only they could report to the Federal Court. Many weeks later, the US Attorney informally let me know that Judge Gould's decision would be ready on 06-16-08.

4. On 06-05-08, I received an unfavorable decision from OMHA. Inspection immediately revealed it was never written by Judge Gould. It frankly disgraces the memory of Judge Gould, who died 06-11-08. I can give a hundred pieces of circumstantial evidence as to why this decision was never authored by Judge Gould, a wise and experienced judge. None of the analysis is necessary because Judge Gould's OMHA employment records will definitively show that in early March 2008, Judge Gould left

F - U. S. DOJ CIVIL RIGHTS

OMHA terminally ill. I was forced to confirm this by writing to Judge Gould's family, through the California Bar Association. The family was kind enough to call me.

5. On 07-25-08, the U.S. Attorney at hearing told Judge Carney that the 06-03-08 decision was that of Judge Gould. Judge Carney has stated in the court record that he will always believe the Officer of the Court. This leaves the civil rights of *pro se* litigants especially vulnerable to U.S. Attorney misconduct. The authorship of the OMHA decision was material to the case. The US Attorney specifically wrote in his Motion for Summary Judgment that my characterization of Judge Gould was proved wrong, so the criminal violations we are litigating against DHHS CMS should be similarly considered to be proved wrong. Three days after the US Attorney intentionally or negligently made this false representation to the Federal Court, Judge Carney REVERSED his 04-01-08 order granting us exhaustion and stayed our case until the DHHS CMS voluntarily waives their sovereign immunity. There was intentional and negligent fraud to: obstruct our right to a fair hearing, to obstruct our right to a second hearing, and to obstruct our active cases. Currently we have:

- a) Petition for Write of Certiorari to the Supreme Court of the United States re: No. 08-56278 and No. 08-56358

F - U . S . D O J C I V I L R I G H T S

- b) US Court of Appeals No. 07-56622
- c) SACV07-01444 CJC-RNB
- d) SACV08-00663 CJC-RNB
- e) Joint LCD C-07-82
- f) Medicare Appeals Council case 1-185294748

There is no question that the US Attorney had an obligation of due diligence to know that Judge Gould left in early March and did not author the decision. I do not know whether the DHHS CMS completely bamboozled the US Attorney in an illegal cover-up or whether he is an active part of it. The bottom line is that the US Attorney, intentionally or negligently, is part of a DHHS CMS cover-up which was intended to deny the rights of our Medicare Part B beneficiaries and myself, their Medicare Part B physician provider and obstruct justice. Your immediate attention to this matter is greatly appreciated. I am also forwarding this to David Sayan with a copy of our US Supreme Court case.

On this the 12st day of December 2008, in the city of Laguna Hills, CA, I declare that this information is true and correct to the best of my knowledge

/s/ Dorothy Calabrese, M.D.

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08-27-79 - Marna Slocum, who participated in our 2005 Joint LCD appeal was awarded social security disability for allergic hypersensitivity to chemicals. Region IX Judge Samuel King ruled that Marna Slocum's extensive allergies, including allergic hypersensitivity to chemicals was disabling medical condition. Marna Slocum is the wife of retired US Secret Service, Presidential detail - Senior Agent - Frank Slocum.

04-25-89 Marna Slocum was awarded Medicare Part B reimbursement for transfer factor immuomodulatory therapy for extensive allergies, abnormal cell mediated immunity and allergic hypersensitivity to chemicals by ALJ Stanley Sadur, Region IX San Francisco Federal Appeals. Judge Sadur determined that the TF was reasonable, medically necessary and covered under Title XVIII Social Security Act after a comprehensive hearing with our Daubert-qualified experts and careful review of the clinical and scientific literature on TF. Transamerica Occidental, the previous Medicare contractor covered TF.

12-02-02 NHIC initiated an audit process triggered by a Contractor computer data entry error. Dr. Calabrese was entered as #27 Pediatric Medicine in the NHIC computers. All the ICD-9 and CPT codes used by Dr. Calabrese were allergy- immunology. This triggered an automatic audit. The audit included all patients for a three-year period ending October 30, 2003. All services, new patient appointments, consulta-

G - CASE TIMELINE

tions, resuscitations, allergy testing, antigen immunotherapy, and transfer factor, were retroactively rejected stating that Dr. Calabrese should have referred all the patients to an allergist-immunologist. The NHIC did not know Dr. Calabrese has been an allergist-immunologist since 1981. Subsequently, NHIC argued that Dr. Calabrese wasn't a Board-certified allergist in violation of Bowen v Michigan Academy.

01-25-03 - Dr. Calabrese submitted relevant favorable DHHS decisions from ALJ Stanley Sadur and Chief ALJ Arthur Cahn Region IX Appeals San Francisco. NHIC rejected these as "not binding." NHIC rejected the legal reasoning employed in these cases with patients with a similar medical condition after full hearing with evidence and expert witnesses.

Early 2003 American Health Lawyers Association [hereinafter AHLA] attorneys cite long practice and pattern of DHHS CMS dirty tricks, secret laws and corruption. Dr. Calabrese retained two AHLA attorneys who independently affirmed that NHIC abuses "medical necessity" as a gatekeeper to ration Medicare benefits and improve their Medicare contract rebidding profile. The first AHLA attorney, Timothy P. Blanchard:

- is a partner in McDermott Will & Emery specializing in insurance issues of medical necessity

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- has testified before the House Committee on Small Business regarding Medicare coverage and medical necessity issues
- addressed Government Accountability Office staff regarding Medicare medical necessity policy issues
- is the author of: "*Medicare Medical Necessity Determinations Revisited: Abuse of Discretion and Abuse of Process in the War Against Medicare Fraud and Abuse*," 43 ST. LOUIS U.L.J. 91 (1999)
- is the author of "*Medical Necessity Denials As A Medicare Part B Cost- Containment Strategy: Two Wrongs Don't Make It Right Or Rational*," 34 ST. LOUIS U.L.J. 939 (1990)
- contributed chapters to the Health Law Practice Guide (Thompson/West) (co- author)
- contributed chapters to the Medicare outpatient prospective payment system compliance, 2002 (co-author))
- is active in the American Health Lawyers Association and has just completed service on its Board of Directors (2001-2007) and chairs AHLA's Annual Institute on Medicare Payment.
- is a Fellow of the Healthcare Financial Management Association • is a member of the editorial review board of Healthcare Financial Management
- is a member of the editorial Advisory Boards of CCH Healthcare Compliance and CCH Health Care

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- is a member of the Editorial Advisory Board for United States Health Care Laws & Rules 2006-2007 (AHLA)
- is a member of the Legal Advisory Committee of the American Academy of Professional Coders.

The second AHLA attorney, Jonathan Schuman is:

- a former Attorney with the Office of General Counsel, Medicare Part B, Baltimore Central Office
- is one of three supervising attorney's for the 9th Circuit in 1978-82
- current a member in good standing since 1973 Florida Bar
- instructor Palm Beach Community College, Am Gov, Political Science
- former Assistant Attorney General, State of Florida
- former health care law advisor, Governor Rubin Askew of Florida.

Both AHLA attorneys stated NHIC would rely on sub rosa policies and "dirty tricks" to deny our class of Medicare beneficiaries appropriate reimbursement.

05-20-03 Dr. Calabrese submitted this case for the Medicare beneficiaries to the US Department of Justice Antitrust Division, 450 Golden Gate Avenue, San Francisco, CA. Top Board-certified allergist-immunologists sent support

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ing letters to the US DOJ including Alan Levin, M.D., J.D. Diplomat of the American Board of Allergy Asthma and Immunology, former California Medical Board expert panel allergy-immunology. The US Department of Justice Antitrust Division SF reviewed the case and accepted it. The SF DOJ ATR attorney explained that private insurance patients have the option of changing insurances. However, Medicare patients have no such insurance options as they have already paid into the system and therefore they need anti-competition protection. The US DOJ Antitrust Division in San Francisco referred our case to the Washington, D.C. office of the US DOJ.

10-03-03 - TF National Coverage Determination [NCD] excludes multiple sclerosis patients:
Transfer factor is the diasylate of an extract from sensitized leukocytes which increases cellular immune activity in the recipient. It is not covered as a treatment for multiple sclerosis because its use for that purpose is still experimental.

Transfer Factor for Treatment of Multiple Sclerosis

(Rev. 1, 10-03-03) CIM 45-17

Medical Manual, Pub. No. 100-3: 160.20 Section 160.20

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Excluding multiple sclerosis was based on careful double-blind studies. NHIC knew for certain that none of our Medicare beneficiaries had multiple sclerosis.

10-30-03 - NHIC preliminary determination delayed from standard 45 days to 1 year. Mary Lou Cartas, the claims analyst state that we could not speak to them prior to the preliminary determination. Once it was released, it was revealed all charges were denied based on the NHIC assertions Dr. Calabrese should have referred all these patients to an allergist-immunologist. Dr. Calabrese called Mrs. Cartas and explained she has specialized in allergy-immunology since 1982 and is a longstanding member of the American College of Allergy, Asthma and Immunology. Mrs. Cartas was incredulous but explained it was too late to make changes as the audit was complete.

10-30-03 - Violation of Sec 1879 [42 USC 1395pp] and Bowen v Michigan Academy: NHIC Drs. Adam and Horowitz illegally demand 3 years retroactive reimbursement - all charges based on the incorrect determination Dorothy Calabrese, M.D. was not an allergist-immunologist.

11-05-03 – Medicare patients sought advocacy from US Senators and Congressmen: US Sena

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tors Barbara Boxer and Diane Feinstein, US House members: Mary Bono, Ken Calvert, Lois Capps, Chris Cox, Rosa De Lauro, Daryll Issa, Ed Royce, Adam Schiff, and Lynn Woolsey. DHHS Secretary Tommy Thompson, Carleen Y. Talley (Director of the CMS Congressional Affairs Group), Henry F. Tyson (Chief CMS Region IX), Jyrita Pixley (Congressional specialist NHIC Marysville, CA)) and Arthur Lurvey, M.D. (CMD of EDS - NHIC for Southern California) refused to do anything.

11-20-03 - NHIC meeting to review the preliminary determination: NHIC staff: Don Adams, M.D. and Tom Horowitz, D.O., Regina Solis, R.N. and Mary Lou Cartas and other staff met with Dr. Calabrese, Scott Matthews MPH (our lab director, on the faculty of Yale University Medical School), Pastor William Davenport (the patient representative) and Luke Calabrese, the office manager. The NHIC staff reviewed their "preliminary determination." They stated the audit was triggered because Dr. Calabrese was miscoded in their computer as #27, which is "Pediatric Medicine." NHIC said that Dr Calabrese needed to change her code to Allergy Immunology. NHIC did nothing to remedy their error when they found out Dr. Calabrese had been an allergist-immunologist for the past 27 years.

Don Adams MD, Tom Horowitz DO and the other NHIC staff stated they had never heard of this clinical diathesis or treatment and

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therefore the patients would simply have to pay cash out of their own pocket. They claimed to have given each beneficiary individual review for a disorder they knew nothing about.

Violation of 42 CFR Parts 400, 405, and 426 NHIC announced at the meeting s new TF non-reimbursement "local policy" which did not meet any new LCD requirements: no LCD docket, no Medicare Part B carrier advisory committee review, no public comment, etc. This violated 42 CFR Parts 400, 405, and 426, which went into effect 11-07-03. Don Adams MD announced to us that a carrier can simply decide "local area policy" and our area (California) "didn't need TF" anymore. Drs. Adam and Horowitz dismissed the fact that the TF NCD meant it was covered nationally except for multiple sclerosis. They rejected Region IX Judge Stanley Sadur's decision for Marna Slocum stating that it wasn't "binding" and "ALJ's aren't real judges." Dr. Adams denied our patients were very sick stating: "all doctors say their patients are sick" and said they should just pay cash out of their own pockets.

NHIC claims sovereign immunity to US DOJ ATR

Drs. Adam and Horowitz dismissed the US Department of Justice's position that all beneficiaries can NOT be forced to individual Medicare appeals because it's unduly anticompetitive.

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Both Dr. Adams and Dr. Horowitz stated that they did not care what the US DOJ ATR said because they have sovereign immunity.

NHIC MDs admit they never even reviewed TF literature Dr. Adams introduced Dr. Horowitz saying: "Here's your immunologist." Tom Horowitz DO is a family practitioner, not an immunologist. Drs. Adams and Horowitz admitted they had never read a single article, literature review, case summary, or any book in the published medical literature on TF despite having been provided with extensive citations ten months earlier. Drs. Adams and Horowitz admitted they had no clinical experience with transfer factor and that they had not exercised due diligence by consulting anyone who did. NHIC admits they never read relevant Sadur & Cahn court decisions. Dr. Adams and Dr. Horowitz admitted that between January 25, 2003 when they received our references and November 30, 2003, they had made no effort to read them.

NHIC said now MD's have to form a PAC and buy your codes - "pay to play." Tom Horowitz DO, bent over and pointed at us saying: "It doesn't matter whether it (transfer factor) works or not. You need to do what everybody else does - what you need to do is to get a group of doctors and put together a PAC (Political Action Group) Others (physicians) got together and fought for their code. That's what you need to do. You

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need to buy your codes." Dr. Calabrese pointed out that a local transplant center was wasting thousands of dollars per patient doing pre-transplant diagnostic work-ups on Medicare patients who did not meet United Network for Organ Sharing (UNOS) qualifications based on preliminary screening questionnaires alone. That if they're concerned about rationing care, their attention needs to be on waste. Dr. Horowitz stated "those doctors bought their codes" and now they "get to do what they want." Both physicians explained that their decisions and statements were based on how they were trained in-house by NHIC.

NHIC sent secret questionnaires to our beneficiaries. Both Dr. Adams and Dr. Horowitz admitted they had sent secret questionnaires to our Medicare beneficiaries intentionally trying to elicit adverse information against Dr. Calabrese and TF. The questionnaires said: "Please answer the following questions WITHOUT consulting the physician mentioned." Our Medicare beneficiaries complained that this was threatening. They stated concerns that their other physicians would be similarly harassed or that their Social Security benefits would be targeted.

NHIC abused the secret patient questionnaires. The Medicare beneficiaries wrote back that this care was extremely important to them

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- lifesaving. There were NO negative comments. Dr. Adams admitted: "they (the questionnaires) didn't work out the way we had hoped." Both Dr. Adams and Dr. Horowitz admitted that NHIC policy includes such as secret questionnaires.

18 USC § 1035(a) false statements relating to health care matters EDS - NHIC Theresa DeBell R.N., and member of the Medicare Part B Carrier Advisory Committee wrote to our Medicare beneficiaries and their Senators and Congressmen stating: NHIC does cover allergen immunotherapy, which describes the use of preservative free allergy extracts. NHIC, however, does not cover transfer factor. Although you may be receiving this through your physician in her office, it is an over-the-counter medication and is usually self-administered. Medicare does not reimburse for medications with this description."

Ms. DeBell did affirm that the antigen immunotherapy should have been covered, but NHIC continued their non-reimbursement policy. NHIC intentionally misled these elected representatives that TF was not medically necessary and not a covered benefit with the clear intent of obstructing our patients from receiving appropriate constituent services. Nurse DeBell was immediately contacted by Dr. Calabrese and multiple Medicare beneficiaries by phone, mail and overnight delivery service. EDS -

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NHIC refused to issue any retractions to our US Senators and US Congressmen. EDS – NHIC and their agent Theresa DeBell RN willingly and knowingly violated 18 USC § 1035(a) false statements relating to health care matters: in any matter involving a health care benefit program, EDS – NHIC and its agent, Theresa DeBell knowingly and willfully (1) falsified, concealed, and/or covered up by any trick, scheme, or device material facts; and (2) made a materially false, fictitious, and/or fraudulent statement and/or representations, and/or made and/or used materially false writing document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services.

12-11-03 - NHIC National Medical Director refuses to get involved. Craig Haug, M.D., National Medical Director of NHIC, received a letter and set of 3 inches of documents sent overnight on behalf of the Medicare beneficiaries by Dr. Calabrese. Dr. Haug refused any help.

12-15-03 - CMS Region IX US Public Health Service Commander Mary Ellen Bruk said there did not need to be an interruption in TF reimbursement. Commander Bruk said she checked national policy and the only restriction against TF is for multiple sclerosis. She gave us a spe

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cific code to use and no longer use the code the previous Medicare Contractor, Transamerica Occidental assigned. Commander Bruk said to contact Carlos C. Rivera 213-593-6834, carlos.c.rivera@eds.com at NHIC so billing would continue with the new code. He had told her that there was no problem except coding should be updated that it is only a coding issue. On repeated occasions, Dr. Calabrese called and left messages for Carlos Rivera, but Carlos Rivera remained totally non-responsive.

02-24-04 - Dr. Calabrese sent a certified-return-receipt package of documents to each of the Electronic Data Systems Board of Directors at the EDS HQ in Plano, Texas and their private addresses so that Medicare reimbursement for ongoing successful medically necessary care would be reinstated on 01-12-04. Not one member of the EDS Board responded, despite the fact that they knew NHIC was under siege for Texas Medicaid fraud in excess of \$34 million, which ultimately cost them that CMS contract. Anne Backoff Dalton, Vice President, Electronic Data Systems Medicare Administrative Services wrote: This is in response to your letter to Electronic Data Systems Corporate headquarters dated February 12, 2004. . . Please be advised that there is no national coverage determination for transfer factor. Furthermore, our medical staff has researched literature and documentation submitted by you

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and found no evidence to consider this treatment the standard in the community.

03-01-04 - Bruce Quinn, M.D., Ph.D., M.B.A. started as the NHIC carrier medical director who contractually is responsible for determining medical necessity. Prior to Dr. Bruce Quinn's arrival there had been no EDS – NHIC California Contractor Medical Director for a full year.

04-01-04 - NHIC Violation of 42 CFR Parts 400, 405, 426 Without any notice to Dr. Calabrese, the Medicare beneficiaries, or the public, NHIC post a non-reimbursement of TF LCD on their Medicare website stating that TF was not medically necessary for any medical condition and not covered. The LCD included many totally false statements, known to Dr. Bruce Quinn to be entirely false. There was no LCD docket, no Medicare Part B CAC review, no 45 day period of public comment, no participation of impacted physician providers as legally required.

05-25-04 - The US Department of Justice Anti-trust Division in Washington, D.C. assigned attorney, Steve Brodsky again contacted Dr. Quinn. He tried to work the reimbursement issue out directly with Dr. Bruce Quinn. The US DOJ position was that NHIC could not force all our Medicare patients to individual beneficiary hearings because it was unduly anticompetitive.

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He wrote to Dr. Quinn: "Since my last e-mail to you I have spoken again with Christine Plumb (CMS Region IX). I think the answer to the question I asked in the e-mail is this . . . for your injectable transfer factor treatments, the problem is not the code. NHIC is denying coverage for that procedure entirely on the ground that transfer factor by pill would be just as effective as injectable."

Dr. Bruce Quinn willingly and knowingly misrepresented to our US DOJ ATR attorney that a homeopathic cow colostrum OTC pill remedy is equivalent to dialyzable leukocyte extract from pooled human donors from a licensed blood bank. In 2004, the FDA issued a warning to marketers of cow colostrum tablets trademarked with the name "transfer factor." The FDA found the marketers to be in violation of the Federal Food, Drug and Cosmetic Act, which prohibits the makers of dietary supplements from marketing them as a means of preventing, diagnosing, mitigating, treating or curing disease. Another major FDA concern is contamination of these cow colostrums tablets as they may derive from cattle with bovine spongiform encephalopathy (BSE). The BSE causing prions can accumulate in the brain and damage nerve cells.

06-04-04 - Diane Caradeuc, CMS Region IX, told our US Department of Justice attorney, Steve Brodsky, stated that all the non-transfer

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factor charges were definitely covered by Medicare. NHIC refused to listen to CMS. In 2005, Diane Caradeuc confirmed that the non-TF charges were definitely covered and should have been paid but stated she had a new position and could not help.

07-07-04 - The US Department of Justice attorney assigned to our Medicare beneficiaries, Steve Brodsky, after working with CMS in Baltimore, said that the Medicare beneficiaries had a separate right to appeal the policy so patients could not be forced to individual Medicare appeals. He wrote: "I am not referring to the non-coverage appeals that individual patients have previously taken to an ALJ, I am referring to a procedure in which an ALJ could order Region IX to change its policy, and overrule NHIC, with respect to all existing and future transfer factor patients in Region IX." Sally Hart, Litigation Counsel for the Center for Medicare Advocacy also recommended we file a Local Coverage Determination. This led to our Joint 2005 Local Coverage Determination, the first ever accepted by the DHHS under BIPA 2000, Sec 522. However we could not file until we had a final determination, which NHIC still refused to issue.

09-30-04 - Our US Department of Justice Anti-trust Division attorney, Steve Brodsky, contacted Dr. Bruce Quinn about his transfer factor policy by phone and Mr. Brodsky wrote back: "I

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spoke at some length with Dr. Bruce Quinn by telephone yesterday. It does not sound encouraging to me. But let's see where we are at after he has reviewed the package I'm sending."

10-01-04 -Our US Department of Justice ATR attorney sent Dr. Bruce Quinn extensive documentation on TF by FedEx because he had to force the final determination if we were ever to have access to any due process. Dr. Bruce Quinn still refuses to consult with Daubert-qualified TF medical expert Alan S. Levin MD (UCSF) Dr. Bruce Quinn refused to consult with Alan S. Levin MD who is Board certified in Allergy and Immunology, Pathology and Dermatology. Dr. Levin was a member of the California Medical Board allergy-immunology panel, a longstanding member of the UCSF Medical Center faculty, a clinician with decades of use of TF in patients with this same low-incidence / low-prevalence clinical diathesis, a TF researcher who published on TF and Daubert-qualified to testify in Federal jury trials on TF. Dr. Bruce Quinn still refuses to consult with Daubert-qualified TF medical expert Vincent Marinkovitch, MD (Stanford), a top allergist-immunologist on the faculty of Stanford University Medical Center since 1964, with extensive clinical experience with TF, had published on TF and was Daubert- qualified to testify in Federal jury trials on TF.

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10-24-04 - Andy Schlafly, counsel for Association of American Physicians and Surgeons (AAPPS) called Dr. Bruce Quinn to get TF reimbursement reinstated. Dr. Bruce Quinn states that it doesn't matter how effective TF is, that we have to prove widespread acceptance like the chiropractors did.

11-05-04 - Instead of a decision in 45 days, which is the statutory guideline, we still had no final decision one year later. Our US Department of Justice Antitrust Division attorney wrote: "It seems to me that Dr. Bruce Quinn may have done, by now, whatever he planned to do in the way of checking the literature or other sources. So, I will plan to give him the issue in which he seemed to be most interested was not whether transfer factor is effective. It was, instead, whether it is a well recognized, and widely recognized form of treatment. His point is that Medicare is "conservative" about the types of treatments and medications it will cover. In that regard it might be useful if you, or any of your contacts, such as the fellow who was a Medicare attorney, Jonathan Schumann, can think of previous cases in which the issue was not whether a treatment is effective, but whether it is widely recognized.' For example, did Medicare initially not cover chiropractic services, or acupuncture, and then there came a time when an Administrator decided that it would be covered (a) because it had become

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"widely recognized" or (b) it had been used long enough, and widely enough, to yield proof that it is effective? Do you or your contacts know of any cases in which Medicare has said something like this: "This type of treatment may be effective, but we are not going to cover it because it is not widely employed by the medical profession?" We requested from Michael Marquis of CMS FOIA all TF information from CMS Region IX and EDS - NHIC. NHIC was totally non-responsive.

12-01-04 - Dr. Bruce Quinn wrote to Dr. Calabrese and our US Department of Justice Antitrust Division attorney:

"As you may recall, I assumed the position of Medical Director at NHIC in March 2004. In September, I received a packet of information forwarded to me by (our US Department of Justice Antitrust Division attorney) at the Department of Justice. I also reviewed your binder of materials dated 11/20/2003 (approximately three inches).

I have reviewed NHIC's postpayment review case presented to you in November 2003. I have reviewed NHIC's brief web article (Exhibit

1) published in April 2004 on non-coverage of transfer factor. I have reviewed additional materials presented within Exhibit 2. I do not see justification to revise our non-coverage of transfer factor, for reasons explained in Exhibit 2. I realize this may be disappointing to you in view of your efforts with NHIC, with Medicare's re

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gional office in San Francisco, and in your exchanges with (your US Department of Justice attorney) and possibly individuals in Medicare's central office in Baltimore.'

'However, I would like to emphasize to you that Medicare has a simplified process through which manufacturers and providers, certainly including minority-opinion providers, may request a National Coverage Decision. In this process, you would follow guidelines on Medicare's website (Exhibit 3) and indeed you would be free to interview resources at Medicare's national coverage center for advice & assistance in your application. A packet such as your 3" binder on transfer factor, or other materials you or other colleagues in minority opinion care find appropriate, would be submitted for review as a national coverage decision for transfer factor.'

'The national coverage decision request has two possible outcomes. In the first, transfer factor is approved based for Medicare nationally, which is of course binding on NHIC. In the second, transfer factor is not approved based on central office guidelines of reasonable and necessary medical care, in which case transfer factor is not and should not be covered by NHIC."

12-15-05 - Under firm pressure from our US DOJ attorney, a final determination was finally released by Dr. Quinn denying reimbursement for all services on all Medicare patients retroactively for the previous three years.

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02-15-05 - We filed with DHHS DAB for an LCD appeal on behalf of our orphan class of Medicare beneficiaries with the same clinical diathesis. Thirty-two Medicare patients participated in the LCD appeal. Because six had finished their care and would not need to resume it, Judge Richard Smith accepted the remaining twenty-six of the patients. Dr. Calabrese was the designated legal representative.

02-15-05 - A timely request was made to EDS - NHIC for individual beneficiary appeals was filed and accepted by NHIC hearing officer, Lilia C. Kleinman. NHIC Independent hearing office sets individual appeals hearing for June 2005 with Drs. Quinn, Adams and Horowitz as witnesses.

03-07-05 - Lilia C. Kleinman confirmed the in-person hearing with witnesses Drs. Quinn, Adams and Horowitz. The tentative date was going to be two weeks after we received the hearing office records. The records were delayed and the tentative date was reset to June 2005.

03-16-05 - DHHS DAB Judge Richard Smith issued an Initial Procedural Order to make the LCD appeal a joint application.

03-30-05 - Georgina Aguilar, NHIC Medicare Hearing Department, wrote: "(Hearing Officer Kleinman) indicated that you are waiting for

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the response to your request for a review of the Local Coverage Determination (LCD) issued by NHIC and will be ready to agree on a schedule for the in-person hearing when the appeal is resolved." We never agreed to delay the in-person individual beneficiaries' hearing until the LCD appeal was decided and had so informed Ms. Kleinman.

05-27-05 - Dr. Bruce Quinn released to FOIA that he and Dr. Arthur Lurvey were the experts and refused to release the other names improperly claiming a 95 USC § 522 (b)(6) exemption: that the interest of such consultants in maintaining their privacy stems from the fact that release of their names could subject them to the clear possibility of disapproval and/or harassment by their peers. In this matter, the consultants have a protectable privacy interest that is not outweighed by the public interest Dr. Bruce Quinn did not have one Daubert-qualified TF expert.

05-27-05 - Michael Marquis (CMS FOIA) stated that in response to our FOIA request, NHIC stated they did not have any TF records of any kind to produce. Under BIPA 2000 Sec 522, if there is no LCD docket, reimbursement is automatically reinstated, but NHIC refuses.

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06-14-05 - DHHS DAB Judge Smith ruled that we successfully met the legal requirements to prove that NHIC had not fully considered the medical and scientific data nor consulted with Daubert-qualified TF experts when they wrote their non-reimbursement of TF LCD.

06-14-05 - NHIC put our redetermination hearing on indefinite hold. An identical set of the LCD documentation is sent to the NHIC hearing officer. Mrs. Kleinman, the NHIC hearing officer again states, claiming conservation of judicial resources, that she was delaying the individual beneficiary hearing until the LCD appeal was adjudicated, even though we made it clear we did not want that.

06-22-05 - 18 USC § 1035(a) false statements re health care matters to CMA: Dr. Bruce Quinn falsely represents to the California Medical Association [CMA] that he has given every consideration to TF reimbursement and it is not medically necessary – policy. On June 22, 2005 Dr. Calabrese, a longstanding member of the AMA and CMA, contacted Elizabeth McNeil, Vice President of the CMA and Director of Federal Issues, looking for the CMS oversight administrator for what was clearly NHIC malfeasance. Ms. McNeill spoke to Dr. Bruce Quinn. He falsely stated that he had bent over backwards to do everything to give TF appropriate consideration for reimbursement, to

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intentionally mislead CMA. He made it clear nonreimbursement was NHIC policy.

10-03-05 - CMS Ombudsman promises immediate assistance. In July 2005, Chief DHHS DAB Judge Marion Silva referred the non-transfer factor reimbursement issues to the CMS Ombudsman, Daniel Schreiner M.H.S. He called back months later in response to Dr. Calabrese many calls. Mr. Schreiner stated the ombudsman position was created by the Medicare Modernization Act of 2003 and he was appointed in March 2005. Mr. Schreiner said that his position was created specifically to address these egregious issues of carrier misconduct and ours would be his first case. He asked that we send documents overnight, which Plaintiffs did. Dan Schreiner said the matter would be immediately investigated, but it never was.

10-12-05 - Judge Smith ruled to the LCD to be an acceptable joint complaint as defined at 42 C.F.R. 426.400 (c) and (d), and 426.410(b). To legally qualify the TF patients had to have a similar medical condition.

11-17-05 - 18 USC § 1001(a)(2) False statements - NHIC Carlos Rivera 18 USC § 1001(a)(1) False entries - NHIC Carlos Rivera 18 USC §1505 Obstruction of Justice - Carlos Rivera

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NHIC review manager, Carlos Rivera, makes a materially false statement to Judge Richard Smith that they are following a NCD On November 17, 2005, Carlos C. Rivera, NHIC Medical review manager, wrote to ALJ Richard Smith: "NHIC, Part B contractor for California, does not have a Transfer Factor LCD. The Medicare Manual does include a NCD which states that transfer factor is not covered as a treatment for multiple sclerosis because its use for this purpose is still experimental (Pub.100-3, Section 160.20) The NCD is the policy that NHIC is following and has published two bulletin articles based on the NCD. The original article was published in our Medicare, "Medicare B Resources" (June 2004, p.72). An update article is located on the NHIC Medicare Website and in CMS's Medicare Coverage Database (MCD) "Article for Transfer Factor - Update (A24754)".

This statement was materially false and was intended to deny jurisdiction to the Medicare beneficiaries and deny them their lawful right to the LCD appeal process. It is not credible Carlos Rivera was unable to differentiate between patients with MS who were excluded under the NCD and our beneficiaries who did not have MS and were not excluded under the NCD. Mr. Rivera has refused to correct this when asked, so this is an intentional misrepresentation. It's not credible that eight months after this LCD appeal was filed, NHIC notices the court for the first time that there was no LCD,

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so there's no jurisdiction. The procedure for the LCD appeal requires that the DHHS DAB first notify the Medicare contractor when the appeal is filed and NHIC made no representations at that time that there wasn't a LCD. Carlos Rivera willingly and knowingly withheld thousands of pages of relevant documents. Carlos Rivera willingly and knowingly made false statements and entries to obstruct justice.

12-12-05 - DHHS DAB ALJ Richard J. Smith wrote:

'A Local coverage determination (LCD) means a decision by a fiscal intermediary or a contractor under Medicare Part A or Part B, as applicable, whether to cover a particular service on an intermediary-wide or contractor-wide basis in accordance with section 1862(a)(l)(A) of the [Social Security] Act. Under this definition, the significant factors are (1) whether the coverage decision is applicable on a contractor-wide basis and (2) whether the coverage decision is based on a determination that the service is not reasonable and necessary in accordance with section 1862 of the Social Security Act."

01-03-06 - CMS Baltimore states there was a policy but in the future they will determine reimbursement on a claim by claim basis. John Warren at CMS Baltimore does not aver

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that our Medicare beneficiaries were denied transfer factor reimbursement due to policy. He wrote to ALJ Richard Smith: "coverage will be determined on a claim by claim basis by the carrier." The problem with Mr. Warren's statement is that it was intended to deny our Medicare beneficiaries their lawful right to the LCD appeal process instead of individual beneficiary hearings, and essentially nullified the rights conferred by the legislature.

02-28-06 - NHIC hearing officer, Lilia Kleinman again refuses Plaintiffs the in-person hearing when Dr. Calabrese explained that waiting for the LCD appeal decision was taking too long to continue to wait. Lilia Kleinman wrote: "On February 21, 2006, you telephoned me and left a message indicting that you would like to schedule your in-person hearing in April 2006. You also indicated that you requested these records from Rosario Cirrincione, Director of POI/Privacy Acts Division of Public Affairs in Washington, D.C. and Christine Plumb from Region IXCMS, received a copy of the FOIA request. This case is considered a FOIA case. We can proceed with your in-person hearing you requested for April 2006 providing that you withdraw your FOIA request. Once I receive this information, I will schedule your in-person hearing request in April. To expedite this process, please submit the FOIA withdrawal request via fax."

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03-08-06 - Daniel Schreiner, CMS ombudsman, wrote: "This has been referred to the Division of Medical Review and Education, Office of Financial management, within the Center for Medicare and Medicaid Services for handling. Specifically, Misty Whitaker has been designated as your point of contact. Should you require further assistance please contact Ms. Whitaker directly at (410) 786-3087." Ms. Whittaker denied that she could help because she was assigned to the LCD challenge team and her job was to fight our LCD appeal. Many subsequent calls to Mr. Schreiner continuing to request help went unanswered. The Ombudsman had no intention of assisting our beneficiaries, which was his clear mandate from the legislature.

05-06-06 - 18 USC § 1001(a)(2) Dr. Bruce Quinn made a materially false statement to the DHHS DAB that the case was about coding not policy: "At issue: While NHIC purports to have retired the non-coverage policy on transfer factor, its article continues to state a position that amounts to the same bar on coverage for any condition. We will permit the parties to make submissions on this Question.' 'NHIC's article on transfer factor was revised sequentially in December, January, and February. The final version is that of February 6, and is attached below. 'Publication of coding and utilization articles is a program directive. The February 6 article is limited to a (1) definition of the service,

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(2) coding guidance, and (3) a summary of utilization data and local medical review data probes. Definitions of service are commonplace in coding guidance. Coding guidance is not an LCD. A summary of recent utilization review is merely a statement of fact. Carriers are explicitly guided and funded by CMS to publish comparative billing reports, including results of medical review probes, on their websites. (Program Integrity Manual, Chapter 1, Section 1.4; attached.) If a probe found services for a given topic to have a 0% error rate, we would say that; if a 50% error rate, we would say that; if a 100% error rate, we would say that. The percentage from 0 to 100% is irrelevant to the status as an article or an LCD, it is simply reported. Nothing in the manual indicates that when a high error rate is encountered, it should not be reported, while a low to moderate error rate should be reported. Need to publish coding guidance. NHIC found it necessary to publish coding guidance, due to the 100% error rate regarding coding. Advance notice is an important principle in coding situations. As to third section on medical utilization review, we followed the routine principles for presenting data from utilization reviews (PIM, Chapter 1, Section 1-4) In the alternative, the situation invites a "rule of reason." We believe if the coding guidance had been published but amputated from the medical review probe results it would imply to almost all non-legal readers, including beneficiaries and providers, that the service was always covered.

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This result would be misleading to one or a few providers using the service, and perplexing to the medical community as a whole. We avoid this result by publishing correct coding guidance (re the 100% coding error rate) and historical utilization review data together. Article cannot be used to adjudicate medical necessity. Unlike an LCD, the final article could be used to correct billing on future claims, but it would be impossible to employ the article to adjudicate medical necessity on future claims. Contractor "consistency" versus LCD. The definition of LCD is telegraphic - "a coverage decision" applied "throughout a geography." Most claims are always reviewed outside of NCDs or LCDs, but consistency may be observed. One would hope that on pairings of similar treatment, condition, and patient, the results would tend toward consistency (1). Take as a hypothetical, we would deny a claim for a copper bracelet to treat cancer yesterday or tomorrow, and throughout our geography, whether San Diego or Sacramento. If we railroad the telegraphic regulatory definition of LCDs to impute a de facto LCD every time several claims are decided consistently, or likely to be decided consistently, this yields an absurdity which was not the intent of regulations defining an LCD. There would be an inferred LCD for copper bracelets, if we denied a claim yesterday in San Diego and today in Sacramento. But there would also be millions of implied LCDs ex

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isting willy-nilly all across Medicare, appearing whenever any several claims reflecting similar treatments for similar individual patients are adjudicated consistently Instead, an LCD or NCD must at the least be a published rationale which can be "used", which can be referred in future adjudications as the rationale for non-coverage (or coverage)."

Bruce Quinn MD Carrier Medical Director

(1) E.g. HCFA Ruling 95-1 assumes the position there will be reasonable consistency at Section 58, in indicating that a practitioner should have known Medicare would not pay for a service after a contractor's prior written notice of denial for a similar or reasonably comparable service.

05-06-06 – 18 USC § 1001(a)(2) Dr. Bruce Quinn made a materially false statement to the DHHS DAB that the case was about coding not policy

05-06-06 - 18 USC § 1001(a)(1) Dr. Bruce Quinn made materially false entries to Judge Richard Smith. Dr. Quinn intentionally withheld hundreds of pages of documentation where NHIC had written that TF was not medically necessary which is policy, not coding.

18 USC §1505 Dr. Quinn obstructed justice to Judge Smith

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Dr. Quinn intentionally made materially false statements and made materially false entries to Judge Richard Smith to obstruct justice so as to deny our Medicare beneficiaries jurisdiction under the LCD appeal statute.

01-24-06 - Judge Richard Smith dismisses LCD appeal: Judge Smith read Dr. Quinn's false statement and wrote in response: "Because it is now apparent that the underlying jurisdictional basis of that ruling was deficient, and that I have no jurisdiction to entertain this matter further, the joint complaint must be, and it is, DISMISSED. In the alternative, if the NHIC policy is an LCD, the challenged provision has been revised and/or withdrawn. For that reason, 42 C.F.R. § 426.420(e)(1) requires that the joint complaint be, and it is, DISMISSED." Pursuant to 42 C.F.R. § 426.465(a), the aggrieved parties may appeal to the Departmental Appeals Board my decision that their complaint is subject to dismissal because the NHIC policy is not an LCD. Pursuant to 42 C.F.R. § 426.465(d)(1), the aggrieved parties do not have the right to appeal my decision that their complaint is subject to dismissal because the contractor has retired the LCD provision(s) under review. The main issue that remained unanswered in Judge Smith's decision was whether or not there was an LCD. If there was, then by law, reimbursement was reinstated. If there was not, there had to be a sub rosa policy for all beneficiaries

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with a similar medical condition to be denied reimbursement.

02-06-06 - We were then forced to appeal the dismissal of the LCD appeal by ALJ Richard Smith. LCD appeal filing was made to the DHHS DAB Appellate Division.

03-08-06 - Daniel Schreiner, CMS Ombudsman, through a phone call from CMS Region IX secretary, Christine Plumb, said we should continue to bill but refused to speak to Dr. Calabrese directly and gave no written protections. We were unable to bill because NHIC had made it a federal crime to do so because it was there policy that the care was not medically necessary.

04-03-06 - Dr. Bruce Quinn makes a series of extensive redactions to the NHIC non-reimbursement of TF LCD. Division for review. In response, Dr. Quinn amended the LCD over and over. He finally sufficiently withdrew the relevant provisions that prohibited reimbursement for TF.

09-09-06 - Dr. Bruce Quinn wrote: "I believe Dr. Calabrese's extraction of unknown blood fractions from unknown donors into patients flatly violates section 1602 of the California Health and Safety Code, making further questions of medical necessity moot. (This assumes Dr. Calabrese is not a California licensed

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blood bank.) ‘The section regulates both transfusions and blood product derivatives.’

Dr. Bruce Quinn had already called the State of California to have them investigate Dorothy Calabrese, M.D.’s laboratory and the State found no violations whatsoever.

09-13-06 - Dr. Bruce Quinn was writing special LCDs for billionaires. In: “What Early Stage Life Sciences Companies Need to Know About Medicare Coverage and Reimbursement” to conferees of the National Venture Capital Association, Dr. Quinn explained advised that if a venture capital firm simply sends its specimens from any state in the US to California, where he is the Medical Director, he’d write them an LCD to guarantee they get paid. Then he states this way these billionaire venture capitalists don’t face the much more expensive and prohibitive requirements of filing for a NCD. Dr. Bruce Quinn’s tag-line is that he can make an “LCD = NCD” for these billionaires. Dr. Bruce Quinn writes on his Powerpoint slide: “the firm can concentrate a bundle of cases (eg. \$1 million) on one Administrative Law Judge.” Dr. Quinn demanded our sick elderly and disabled Medicare beneficiaries living on social security disability do a National Coverage Determination, an impossible hurdle for a tiny group of seniors and disabled beneficiaries with a low-incidence, low-prevalence medical condition.

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10-11-06 - Dr. Bruce Quinn wrote to members of the Medicare part B Carrier Advisory Committee (CAC): See Appendix R: "my best judgment is that [Dr. Dorothy Calabrese] actually cannot tell right from wrong or fantasy from reality regarding her extremely bizarre medical treatments. She actually seems to believe e.g. that Senator Feinstein wants my personal medical license revoked, and so on. That the U.S. Department of Justice actually will very soon put NHIC executives in prison, and so on. So possibly there is a limitation of liability issue involved."

10-11-06 - NHIC's Pat Steele started an illegal collection action with PRG Schulz against Dr. Calabree for the three year retroactive liability. We referred him to our US DOJ attorney, Steve Brodsky and the collection action was stopped. Pat Steele said he was told we had lost out LCD appeal and it was explained that we were appealing to the DHHS DAB.

10-12-06 - DHHS DAB issued Final Agency Decision. The Federal code states that if the relevant provisions are withdrawn, reimbursement is reinstated. The legislature is quite clear that was their intent. Furthermore, the DHHS DAB warned NHIC that they could not use the LCD sub rosa. The LCD appeal was over. Our US DOJ ATR attorney, Steve Brodsky stated: "You won." The DHHS DAB issued a Final Decision on review of administrative law judge decision:

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(1) "The ALJ . . .held that the article at issue. . . did not constitute an LCD. . . We disagree with the ALJ about whether the original policy constituted an appealable LCD"

(2) "the relevant provisions were withdrawn, which has the same effect as a decision under 68 FR 63,707, at 63,698; 68 FR 63,712 § 426.460(b)"

(3) "the challenged LCD provision has been retired or withdrawn prior to a decision on the merits. The appeal is dismissed."

Appellant Paul Messer disagreed with these DAB rulings:

(1) "We have no basis here, however, to presume that the contractor will fail to comply with its responsibilities under the regulations."

(2) "On appeal, Dr. Calabrese argues that Dr. Bruce Quinn, who wrote this letter on behalf of NHIC, deliberately misled the ALJ by suggesting that the article addressed coding rather than coverage policy. We do not find evidence of a "fraud" or "cover-up" as alleged by Dr. Calabrese."

12-15-06 - SACV06-1217 CJC – RNBx was filed with 8 criminal violations that constituted Constitutional violations

False Statements & Entries: 18 USC § 1001(a)(1); 18 USC § 1001(a)(2); 18 USC 1035(a);

Obstruction of Justice: 18 USC §1505

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Medicare Violations: 42 USC § 1395; 42 CFR Parts 400, 405, 426; 42 USC 1395pp Sec 1879

03-28-07 - Violation of the Due Process clause of the 5th Amendment: Charity Horton, the NHIC independent hearing office denies hearing and declares retroactive liability on all Medicare beneficiaries for all services retroactively for ~ the past three years, more than 90 days after we filed SACV06-1217 CJC(RNBx). This was used to retroactively deny Dorothy Calabrese, M.D. standing in the Federal District Court. Charity Horton also violated 42 CFR 405.826, 42 CFR 405.824, 42 CFR 405.830(a), 42 CFR 405.830(b), 42 CFR 405.830(d), 42 CFR 405.833, 42 CFR 405.834, 42 CFR 405.836, and Medicare Modernization Act Revisions to 42 USC 1395ff Sect 933, 937, 940.

04/02/2007 - EDS – NHIC Independent Hearing officer Charity Horton. Plaintiffs request determination regarding NHIC denial of in-person hearing with witnesses Bruce Quinn, MD, Don Adams, MD, and Tom Horowitz, DO; Declaration of Dorothy Calabrese, MD. Request that EDS NHIC be ordered to reverse this hearing officer's determination so that we can have our hearing.

07-18-07 - Dr. Bruce Quinn violates 18 USC § 1035(a) to Medicare CAC . Dr. Bruce Quinn violates 18 USC § 1505 Obstruction of Justice.

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Dr. Bruce Quinn willingly and knowingly violated:

- a. 18 USC § 1035(a) – making false statements relating to health care matters to Medicare Part B CAC
- b. MMA 2003 for fraud, gross negligence and reckless disregard
- c. Section 522 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protections Act of 2000 (hereinafter BIPA 2000 Sec 522)
- d. Chapter 13 of the Medicare Program Integrity Manual
- e. 18 USC § 1505 Obstruction of Justice

08/20/2007 - Defendants file Joint Motion to Dismiss for failure to exhaust & sovereign immunity

08/30/2007 - Plaintiff's Response to Motion to Dismiss Case

09-19-07 - Order granting Motion to Dismiss:
Minutes of (in chambers) order by Judge Cormac J. Carney: granting defendants' motions to Dismiss Plaintiff's Second Amended Complaint re: Motions 53 and 54 . Accordingly, the hearing set for 9/24/07 at 1:30 p.m. is hereby vacated and off calendar. Case Terminated. There was never any in-person hearing.

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(a) "Accordingly, the Court finds that it does not have subject matter jurisdiction over Plaintiff's claims because they have failed to exhaust their administrative remedies in compliance with § 405(h) and § 405(g)."

(b) "Accordingly, the Court finds that Plaintiffs' claims against both the government and private individual defendants are also barred by the doctrine of sovereign immunity."

10/05/07 - Judgment by Judge Cormac J. Carney: it is ordered and adjudged that Plaintiffs take nothing from this action, that the action be dismissed in its entirety and that Defendants and Real Party in Interest recover their costs pursuant to a Bill of Costs filed in accordance with 28 USC 1920.

10-06-07 - 18 USC § 1035(a) –false statements health care to AAAAI; Dr. Bruce Quinn (1) falsified, concealed, and/ or covered up by trick, scheme, and/or device material facts to American Academy of Allergy, Asthma and Immunology (AAAI) and (2) made materially false, fictitious, and/or fraudulent statements and/or representations, and/or makes or uses any materially false writings and/or documents knowing the same to contain materially false, fictitious, and/or fraudulent statement and/or entry to AAAAI, in connection with the delivery of or payment for health care benefits, items, and/or services.

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11/10/2007 - US Court of Appeals for the Ninth Circuit Appeal Case 07-56622 Docketed

12-14-07 SACV07-01444 CJC-RNB filed

COMPLAINT against defendants US Dept of Health and Human Services, Michael O Leavitt. filed by plaintiffs Paul Messer, Dorothy Calabrese.

18 USC § 1621 Perjury - TF not CMB approved
- Dr. Bruce Quinn, willingly and knowingly, under penalty of perjury, testified to OMHA Judge Richard Gould that TF was not California Medical Board approved when he knew for certain it was.

18 USC § 1621 - Perjury – TF not a therapy for any condition - Dr. Bruce Quinn, willingly and knowingly, under pe

nalty of perjury, testified to OMHA Judge Richard Gould that TF was a therapy for any medical condition when he knew for certain it was.

18 USC § 1621 Perjury: TF not proved safe and effective - Dr. Bruce Quinn, willingly and knowingly, under penalty of perjury, testified to OMHA Judge Richard Gould that TF was not proved safe and effective in the medical literature when he knew for certain it was.

18 USC § 1505: Obstruction of Justice I

Dr. Bruce Quinn, willingly and knowingly, intended to obstruct justice at OMHA hearing by using of fraudulent AAAAI document in our OMHA hearing before Judge Richard Gould.

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18 USC § 1505: Obstruction of Justice II

Dr. Bruce Quinn, willingly and knowingly, intended to obstruct justice at OMHA hearing by using a fraudulent LCD in our OMHA hearing before Judge Richard Gould.

18 USC § 1505: Obstruction of Justice III

Dr. Bruce Quinn, willingly and knowingly, intended to obstruct justice when he committed perjury stating TF not California Medical Board approved at our OMHA hearing before Judge Richard Gould.

18 USC § 1505: Obstruction of Justice IV

Dr. Bruce Quinn, willingly and knowingly, intended to obstruct justice when he committed perjury stating TF not a therapy for any medical condition at our OMHA hearing before Judge Richard Gould.

18 USC § 1505: Obstruction of Justice V

Dr. Bruce Quinn, willingly and knowingly, intended to obstruct justice when he committed perjury stating TF was not proved safe & effective in literature at our OMHA hearing before Judge Richard Gould.

12-17-07 After being denied any due process for 5 years and 17 days, our OMHA administrative law hearing was held on, by the Honorable Richard B. Gould.

02/05/08 SACV07-01444 CJC-RNB EX PARTE APPLICATION for Order for Allowing Plaintiff Medicare Claims Submissions & Appeals with

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out losing Standing. Filed by plaintiffs Paul Messer, Dorothy Calabrese

02/05/08 SACV07-01444 CJC-RNB Opposition to Ex Parte Application filed by Defendants US Dept of Health and Human Services, Michael O Leavitt

02/13/08 SACV07-01444 CJC-RNB MINUTES OF IN CHAMBERS ORDER held before Judge Cormac J. Carney DENYING EX PARTE APPLICATION for Order for Allowing Plaintiff Medicare Claims Submissions & Appeals Without Losing Standing. Because Dr. Calabrese's request for declaratory relief arises under the Medicare Act and because she has not yet fulfilled the exhaustion requirement, this Court lacks jurisdiction to grant her request.

03/07/08 SACV07-01444 CJC-RNB EX PARTE APPLICATION for Order for CMS Instructions on the Exact Steps they Require for Exhaustion that have not been met. Filed by plaintiff Dorothy Calabrese

03/10/08 SACV07-01444 CJC-RNB NOTICE OF MOTION AND MOTION to Dismiss Case ; *Memorandum of Points and Authorities in Support Thereof* filed by defendant Michael O Leavitt. Motion set for hearing on 3/31/2008 at 01:30 PM before Judge Cormac J. Carney.

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03/10/08 SACV07-01444 CJC-RNB Opposition to Ex Parte Application filed by Defendants US Dept of Health and Human Services, Michael O Leavitt (Chittenden, Russell)

03/10/08 SACV07-01444 CJC-RNB MINUTES OF IN CHAMBERS ORDER held before Judge Cormac J. Carney DENYING EX PARTE APPLICATION for Order for CMS Instructions on the Exact Steps they Require for Exhaustion that have not been met

03/12/08 SACV07-01444 CJC-RNB MINUTES OF IN CHAMBERS ORDER held before Judge Cormac J. Carney DENYING EX PARTE APPLICATION for Order for CMS Instructions on the Exact Steps they Require for Exhaustion that have not been met

03/12/08 SACV07-01444 CJC-RNB EX PARTE APPLICATION for Order for Oral Advocacy at the 3/31/08 Hearing on Motion to Dismiss. Filed by plaintiff Dorothy Calabrese

03/19/08 SACV07-01444 CJC-RNB ORDER by Judge Cormac J. Carney: The Court GRANTS Plaintiffs' ex parte application for oral advocacy at the 3/31/08 hearing for [Defendants] motion to dismiss. The Court will conduct a hearing on Defendants' motion and Plaintiffs will be permitted to make oral argument

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03/20/08 SACV07-01444 CJC-RNB

OPPOSITION to MOTION to Dismiss Case ; *Memorandum of Points and Authorities in Support Thereof* . Filed by Plaintiff Dorothy Calabrese

03/25/08 SACV07-01444 CJC-RNB REPLY in Support MOTION to Dismiss Case ; *Memorandum of Points and Authorities in Support Thereof* filed by Defendants Michael Mukasey, US Attorney, US Dept of Health and Human Services, Michael O Leavitt.

03/31/08 SACV07-01444 CJC-RNB MINUTES OF Motion to Dismiss Hearing held before Judge Cormac J. Carney: Court's tentative ruling issued to counsel before case called. Court hears oral arguments. Court rules in accordance with tentative. Final order to be issued. Court further directs counsel for government to prepare, serve, and lodge a proposed order within 10 days requesting the ALJ to advise the court as to the timetable for his decision and the issues to be addressed therein

04/01/08 SACV07-01444 CJC-RNB MINUTES OF IN CHAMBERS ORDER held before Judge Cormac J. Carney DENYING Defendant's MOTION to Dismiss Plaintiff's Second Amended Complaint ; *Memorandum of Points and Authorities in Support Thereof*

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04/11/08 SACV07-01444 CJC-RNB ORDER by Judge Cormac J. Carney. Pursuant to the Court's Order of 3/31/08, defendant Michael O. Leavitt, Secretary of Health and Human Services is ordered to report to the Court re: the status of the pending Medicare administrative proceeding styled In Re Order Against Dorothy Calabrese, MD

05/16/08 SACV07-01444 CJC-RNB NOTICE OF MOTION AND MOTION for Partial Summary Judgment as to Legal Issue of Sovereign Immunity for Violating the Due Process Clause of the Fifth Amendment. Filed by plaintiff Dorothy Calabrese. Motion set for hearing on 6/9/2008 at 01:30 PM before Judge Cormac J. Carney. Lodged Order

05/23/08 SACV07-01444 CJC-RNB JOINT REPORT Rule 26(f) Discovery Plan ; estimated length of trial 5 Days, filed by Defendants Michael Mukasey, US Attorney, US Dept of Health and Human Services, Michael O Leavitt.

06/03/08 OMHA Appeal 1-185294748 ALJ Ellen Koldewey issues an unfavorable decision, uses Judge Gould's name on the title page and signs Judge Gould's signature by proxy. Judge Gould had left OMHA in early March and did not write the decision.

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06/05/08 SACV07-01444 CJC-RNB NOTICE OF MOTION AND MOTION to Compel Responses to Discovery. Filed by plaintiff Dorothy Calabrese. Motion set for hearing on 7/1/2008 at 09:30 AM before Judge Cormac J. Carney.

06/05/08 SACV07-01444 CJC-RNB Joint Written STIPULATION to Compel Written Discovery. Filed jointly by Paul Messer, Dorothy Calabrese, US Dept of Health and Human Services, Michael O Leavitt

06/06/08 SACV07-01444 CJC-RNB MINUTES OF In Chambers Conference held before Magistrate Judge Robert N. Block: RE Plaintiffs' Motion to Compel Discovery Under FRCP 37, filed 6/5/08. With the District Judge's concurrence, this Motion is ORDERED off calendar without prejudice to its refiling after the District Judge decides the immunity issue, provided that the District Judge then authorizes plaintiffs to proceed with discovery on any of their claims.

06/06/08 SACV07-01444 CJC-RNB STATUS REPORT on OMHA Appeal 1-185294748 Ruling filed by Plaintiff Dorothy Calabrese

06/06/08 SACV07-01444 NOTICE OF LODGING filed *ALJ Decision re Order*

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06/09/08 SACV07-01444 CJC-RNB
OPPOSITION to MOTION for Partial Summary Judgment as to Legal Issue of Sovereign Immunity for Violating the Due Process Clause of the Fifth Amendment filed by Defendants US Dept of Health and Human Services, Michael O Leavitt.

06/09/08 District Court SACV08-00633 CJC-RNB filed

COMPLAINT against defendants US Dept of Health and Human Services, Michael O Leavitt, Leslie V Norwalk, Perry Rhew, Ellen Koldewey, Does 1-10., filed by plaintiffs Paul Messer, Dorothy Calabrese, M. D.

Causes of action: Violations

- due process clause of the Fifth amendment
- 18 USC § 1505 - obstruction of justice
- Discrimination
- Medicare Modernization Act of 2003

06/10/08 SACV07-01444 CJC-RNB MINUTES OF IN CHAMBERS ORDER held before Judge Cormac J. Carney: Order Staying Discovery, Instructing

Defendants to File a Cross-Motion for Summary Judgment, and Continuing Hearing on Plaintiff's Motion for Partial Summary Judgment. Defendants shall file a cross-motion for summary judgment on the issue of sovereign immunity by June 23, 2008. Plaintiffs' opposition

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to Defendants' motion shall be submitted by Tuesday, July 1, 2008, and Defendants' reply brief is due on Tuesday, July 8, 2008. The hearing on both parties' motions for summary judgment shall take place on July 14, 2008 at 1:30 pm Accordingly, Plaintiffs' motion for partial summary judgment is continued from June 23, 2008 to July 14, 2008 at 1:30 pm.

06-11-08 The Honorable Richard B. Gould, a wise and kind jurist died.

06-23-08 SACV07-01444 CJC-RNB NOTICE OF MOTION AND Cross MOTION for Summary Judgment ; *MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF* filed by defendant US Dept of Health and Human Services, Michael O Leavitt. Motion set for hearing on 7/21/2008 at 01:30 PM before Judge Cormac J. Carney.

06-27-08 SACV07-01444 CJC-RNB SCHEDULING ORDER by Judge Cormac J. Carney:

1 All discovery, including discovery motions, shall be completed by September 19, 2008. Discovery motions must be filed and heard prior to this date.

2 The parties shall have until November 19, 2008 to file all other motions, including motions to join or amend the pleadings.

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3 A Pretrial Conference will be held on Monday, December 22, 2008 at 3:30 p.m. Full compliance with Local Rule 16 is required.

4 The court trial of the case shall begin on Tuesday, December 30, 2008 at 9:00 a.m. IT IS SO ORDERED. IT IS FURTHER ORDERED that the Clerk of the Court shall serve copies of this Order on counsel for the parties in this matter.

06-27-08 SACV07-01444 CJC-RNB ORDER REGARDING SETTLEMENT Procedures, Pre-Trial Conference and Trial by Judge Cormac J. Carney: This matter is assigned for all purposes to the Honorable Cormac J. Carney, United States District Judge, Courtroom 9B, Ronald Reagan Federal Building and United States Courthouse, 411 West Fourth Street, Santa Ana, California, 92701-4516. The Court's mandatory procedures and requirements for Settlement, the Pre-Trial Conference and Trial are as follows: (See document for further details.) IT IS SO ORDERED. IT IS FURTHER ORDERED that the Clerk of the Court shall serve, by United States mail, copies of this Order on counsel for the parties in this matter.

06-27-08 SACV07-01444 CJC-RNB EX PARTE APPLICATION for Order for Clarification of Court Order of 6/27/08 filed by plaintiff Dorothy Calabrese

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07-03-08 SACV07-01444 CJC-RNB REPLY IN SUPPORT Cross MOTION for Summary Judgment ; *MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT THEREOF* filed by Defendants US Dept of Health and Human Services, Michael O Leavitt

07-03-08 SACV07-01444 CJC-RNB

MINUTES OF IN CHAMBERS ORDER held before Judge Cormac J. Carney: granting EX PARTE APPLICATION for Order for Clarification of Court Order of 6/27/08 . On 06/10/08 the Court entered an order staying all discovery pending the outcome of the parties motions for partial summary judgment. That order is still in full force and effect. On 6/27/08 the Court entered a scheduling order stating that all discovery shall be completed by 09/19/08. In light of the stay, etc., after the motions for partial summary judgment are resolved, either party may file a motion to continue the discovery cut-off and trial dates, if that party feels such a continuance is necessary. (see minute order for details)

07-14-08 SACV07-01444 CJC-RNB

MINUTES OF IN CHAMBERS ORDER by Judge Cormac J. Carney: CONTINUING HEARING ON Cross MOTIONS for Partial Summary Judgment: The Court, on its own mo-

tion, continues the hearing on the parties cross-motions for partial summary judgment to Tues

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day, July 22, 2008 at 9:00 a.m. The hearing currently scheduled for Monday, July 21, 2008 is hereby taken off calendar. The Court will not issue a tentative ruling at the hearing, and instead will take the matter under submission after hearing oral argument. Each side will have twenty minutes to make oral argument and an additional five minutes in rebuttal. The Court encourages the parties to focus their argument on the issues of sovereign immunity and jurisdiction, the subjects of their cross-motions for partial summary judgment.

07-22-08 SACV07-01444 CJC-RNB MINUTES OF Motion Hearing held before Judge Cormac J. Carney taking under submission MOTION for Partial Summary Judgment as to Legal Issue of Soverign Immunity for Violating the Due Process Clause of the Fifth Amendment

MINUTES OF Motion Hearing held before Judge Cormac J. Carney taking under submission MOTION for Partial Summary Judgment as to Legal Issue of Soverign Immunity for Violating the Due Process Clause of the Fifth Amendment

Hearing on Summary judgments – The US Attorney lies to the Federal District Judge and states that Judge Gould wrote the unfavorable OMHA decision 06-03-08. He did this to gain

unfair advantage in the Motions for summary judgments.

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07-25-08 SACV07-01444 CJC-RNB ORDER by Judge Cormac J. Carney, GRANTING IN PART and denying In Part Parties' Cross-Motions for Partial Summary Judgment. re MOTION for Partial Summary Judgment as to Legal Issue of Sovereign Immunity for Violating the Due Process Clause of the Fifth Amendment , and Cross MOTION for Summary Judgment: Because Plaintiffs have not yet exhausted their claims for benefits, which are inextricably linked to the claims of the Second and Third Federal Actions, Plaintiffs cannot at this time demonstrate that Defendants have waived their sovereign immunity pursuant to the APA. The Court encourages Plaintiffs to complete the administrative process so that the Court has jurisdiction to hear their claims. Pending exhaustion, the Court now stays all proceedings in connection with the Second Federal Action, Case No. SACV 07-1444 CJC (ANx), and the Third Federal Action, Case No. SACV 08-633 CJC(RNBx).

07-25-08 SACV08-00663 CJC-RNB MINUTES OF IN CHAMBERS ORDER by Judge Cormac J. Carney, STAYING CASE: Pursuant to the Court's order in Case No. SACV 07-1444, Grant-

ing in Part and Denying in Part Parties Cross-Motions for Partial Summary Judgment, dated July 25, 2008, the Court now stays all proceedings in connection with Case No. SACV 08-633. Plaintiffs may move to lift the stay once they

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have exhausted their administrative claims for benefits before the Centers for Medicare & Medicaid Services of the Department of Health and Human Services

07-29-08 SACV07-01444 CJC-RNB NOTICE OF APPEAL to the 9th CCA filed by Plaintiffs Paul Messer, Dorothy Calabrese. Appeal of Order,, Filed On: 7/25/08;

07-29-08 SACV08-00663 CJC-RNB NOTICE OF APPEAL to the 9th CCA filed by Plaintiffs Paul Messer, Dorothy Calabrese. Appeal of Minutes of In Chambers Order Filed On: 07/25/08; Entered On: 07/28/08

09-11-08 SACV07-01444 CJC-RNB ORDER from: 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals filed by Dorothy Calabrese, Paul Messer, CCA # 08-56278. A review of the record demonstrates that this court lacks jurisdiction over this appeal because the order challenged in the appeal is not final or appealable. See Fed. R. Civ. P. 54(b); Chacon v. Babcock, 640 F.2d 221, 222(9th Cir.1981)(order is not appealable unless it disposes of all claims as to all parties or judgment is entered in com-

pliance with rule); see also 28 U.S.C. 1291; Silberkleit v. Kantrowitz, 713 F.2d 433, 434 (9th Cir. 1983)(grant or denial of a stay of proceedings is not generally a final decision appealable under 1291). Consequently, this appeal is dis

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missed for lack of jurisdiction. Order received in this district on 9/15/08.

09-12-08 SACV08-00663 CJC-RNB ORDER from 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals filed by Dorothy Calabrese, Paul Messer, CCA # 08-56358. The Order is dismissed. Appeal dismissed for lack of jurisdiction. Order received in this district on 9/16/08

12-08-08 SACV08-00663 CJC-RNB Filed order (HARRY PREGERSON, M. MARGARET MCKEOWN and N. RANDY SMITH) Appellants' motion for reconsideration of this court's September 12, 2008 order dismissing this appeal for lack of jurisdiction is denied. This court lacks jurisdiction over this interlocutory appeal. No motions for reconsideration, rehearing, modification, clarification, stay of the mandate or any other submissions shall be filed or entertained in this closed docket.

12-08-08 SACV07-01444 CJC-RNB ORDER from 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals filed by Dorothy Calabrese, Paul Messer, CCA # 08-56278. Appel-

lants's motion for reconsideration of this court's September 11, 2008 order dismissing this appeal for lack of jurisdiction is denied.

H - 9TH CIRCUIT NO. 07-56622

Excerpt

The District Court writes p 7 ¶ 1: "the gravamen of the SAC is Plaintiff's disagreement with the carrier's application of Medicare reimbursement provisions."

Respectfully, the gravamen is no more:

I. IRREPARABLE HARM

CMS cannot allow the Contractor to stop reimbursement for ongoing successful medical care and deny access to new patients as was done for five years causing irreparable harm to the lives of our vulnerable Medicare patients.

II. ANTICOMPETITION

CMS cannot allow the Contractor to give majority-opinion subspecialists competitive position and dominance because they control the powerful professional organizations, which the Contractor relies on to leverage advantage in Medicare contract renewals.

III. RATIONING OF MEDICARE

CMS cannot allow the Contractor to abuse medical necessity determinations as a gatekeeper to ration Medicare benefits. The Contractor cannot use "overpayment" and "retroactive liability" statistics to leverage advantage in Medicare contract renewals... Tim Blanchard also testified on this before the US House Subcommittee on Small Business and former CMS Administra-

tor Tom Scully (now health care lobbyist with Alston & Bird LLP). Scully promised these CMS reforms before the subcommittee but never delivered.

IV. VIOLATIONS

CMS cannot allow the Contractor to commit Constitutional, statutory, contractual and regulatory violations.

V. FRAUD

CMS cannot allow the Contractor to commit fraud, gross negligence and reckless disregard with the intent to obstruct justice. The Contractor knowingly and willfully:

- (1) falsified, concealed, and/or covered up by any trick, scheme, and/or device material facts
- (2) made materially false, fictitious, or fraudulent statements and/or representations
- (3) made and/or used false writings and/or documents knowing the same to contain any materially false, fictitious, and/or fraudulent statements and/or entries and
- (4) in matters involving a health care benefit program (Medicare) falsified, concealed, and/or covered up by any trick, scheme, and/or device material facts and made materially false, fictitious, or fraudulent statements or representations, and made or used materially false writing and/or document knowing the same to contain

any materially false, fictitious, and/or fraudulent statement and/or entry, in connection with the delivery of or payment for health care benefits, items, and/or services.

VI. FUTILITY

This is a real and practical world. HHS interpretation of exhaustion cannot be the equivalent of "bring me the ruby slippers," which is the opposite of Supreme Court and legislative intent for exhaustion.

VII. COLOR OF AUTHORITY

The Contractor derives its authority from the CMS. The Contractor cannot hide behind color of authority for all these bad acts.

VIII. COLLATERALITY

CMS and the Contractor cannot take the threshold issues of this case and explode them into endless collateral issues and multiple courts so as to avoid judicial economy and create a legal hurdle that is so high, no Medicare Part B physician provider or beneficiary can possibly survive.

IX. DISCRIMINATION

CMS cannot allow Contractor discrimination against a subclass of disabled patients. In matters of this case, the Contractor Medical Director, Dr. Bruce Quinn, carefully wordsmiths to skew context and invariably abuses the term

"multiple chemical sensitivity" to poison the well against these disabled patients with CMS, the California Medical Association, the Academy of Allergy, Asthma, and Immunology, top academics, and many others, with clear intent to obstruct justice. Legal discrimination is well documented against our disabled patients who report "multiple chemical sensitivity" symptoms. See FAC discussion re: *When Science is Too Daunting: Multiple Chemical Sensitivity, Federal Courts, and the Struggling Spirit of Daubert* 11 Vill. Envtl. L.J. 273 (2000)

Among many majority-opinion allergist-immunologists, "multiple chemical sensitivity" is the equivalent of the "N" word in the fifties. These Medicare beneficiaries have "allergic hypersensitivity to chemicals" which is a tiny subpopulation of the discriminated class of patients with "multiple chemical sensitivity." In early 2003, Dr. Calabrese paid two American Health Lawyers Association attorneys who independently predicted back then all these terrible CMS actions and inactions that have actually happened over the past five years. Jonathan Schuman told our US Department of Justice attorney, Steve Brodsky, he will voluntarily give the government all the details of the Contractor "dirty tricks" toolbox and "roadmap of corruption" that allows: the "*irreparable harm*," the "*anticompetition*," the "*rationing of medicare*," the "*violations*," the "*fraud*," the "*futility*," "*abuse of color*

of authority," the "collaterality," and the "discrimination."

DE NOVO REVIEW OF STANDING

Porter v. Jones, 319 F.3d 483, 489 (9th Cir. 2003).

A. Executive branch v. judicial branch interpretations of exhaustion The District Court wrote p 8 ¶2: "**The Court need not engage in a lengthy inquiry to decide whether Plaintiffs have exhausted their administrative court remedies because Plaintiffs fully admit they have not done so.**"

It is a matter of record that neither Appellant had any administrative remedies to exhaust on 12-15-06. There were no claims adjudication. There was no request for monetary damages. Furthermore, in their November 8, 1999, Shala-la v Illinois Council on Long Term Care hearings, the Supreme Court said:

"Exhaustion means, you give the Secretary a chance to pass on it, so you write the Secretary a letter and say, Dear Secretary, I think your reg is out to lunch, but you have a chance to pass on it first, so pass on it. And then, having done that, they bring the results to court, without having to violate the statute. There, we have both

ripeness and exhaustion. What's wrong with that?"

[Shalala v. Illinois Council on Longterm Care, Inc. (98-1109) 529 U.S. 1 (2000) 143 F.3d 1072, reversed]

Appellants met the US Supreme Court interpretation of exhaustion. Former Secretary Tommy Thompson was contacted by our US Congressman Ken Calvert and asked to investigate these matters four years ago. CMS could have made all these issues go away entirely by instituting proper reforms. Instead CMS Region IX head, Ron Ho stated that they were told no one could even talk to Appellants.

At any time, CMS can and should make all of these complaints moot by doing the right thing, by identifying and correcting the underlying root cause of these problems and referring Dr. Quinn for independent investigation. It is CMS that refuses to exhaust their remedies, while they actively obstruct Appellants from judicial review through futility. How many other Medicare Part B physician providers and beneficiaries have had to walk away on these same issues because CMS will not remedy itself?

District Court interpretation-U.S. Supreme Court intent

The District Court wrote p 9 ¶ 1: "Plaintiffs also complain about the delays associated with administrative review which will be detrimental to them and Medicare patients. . . The Supreme Court addresses this concern in Shalala. . . But this assurance comes at a price, namely, occasional individual, delay-related hardship. In the context of a massive, complex health and safety program such as Medicare. . . paying this price may seem justified."

The Shalala affirming Supreme Court Justices Breyer, Rehnquist, O'Connor, Souter, and Ginsburg never envisioned "occasional individual, delay-related hardship" in Part B Medicare to allow: the "*irreparable harm*," the "*anticompetition*," the "*rationing of Medicare*," the "*violations*," the "*fraud*," the "*futility*," "*abuse of color of authority*," the "*collaterality*," and the "*discrimination*."

Paul Messer exhausted all administrative remedies prior to filing

Dr. Calabrese always accepted assignment of Medicare benefits. Mr. Messer never had any claims to adjudicate. Paul Messer was one of the 26 Medicare beneficiaries who participated in the Joint 2005 Local Coverage Determination (hereinafter LCD) Appeal under BIPA 2000 Sec

tion 522 (hereinafter BIPA 2000). This Federal case was filed 12-15-06 so as to meet the 60 day filing requirement of that final agency decision.

Dr. Calabrese had no administrative remedies to exhaust prior to filing

After Appellees launched the fraudulent retroactive liability torpedo, Dr. Calabrese asked the District Court for bifurcation and stay of new issues. In our Response to Defendants' Motion to Dismiss, Appellants wrote: ¶ 21d: excluding any issues that qualify for administrative court process and ¶ 337: "Plaintiffs request this Court to bifurcate and stay the Sixteenth cause of action." This was reasonable request and would have led to substantial justice. Now it is moot because Dr. Calabrese has met the exhaustion requirement

The FAC was torpedoed by the fraudulent retroactive liability

The District Court wrote p8 ¶1: "The SAC appears to have abandoned Plaintiff's original claim in favor of pursuing claims regarding overpayment determinations and reimbursement claims."

The SAC reflects the fraudulent retroactive liability torpedo and illegal US Treasury collection action that immediately threatened to shut down Appellant's medical practice, force bankruptcy and end the case. Furthermore, Dr. Calabrese went to the Office of Medicare Hearings

and Appeals (hereinafter OMHA) with the "retroactive liability" and all jurisdictional issues in this case (and the jurisdictional issues in SACV07-1444 CJC-RNB (filed 12-14-07) on December 19, 2007.

Judge Richard B. Gould is providing his written rulings. Dr. Calabrese accepts The Honorable Richard B. Gould's rulings, asks them to be incorporated and thus has met any agency interpretation of exhaustion.

Appellants qualify for the "roadblock" exception

U.S. Supreme Court also recognizes that not only when administrative regulations foreclose judicial review, but also when roadblocks practically cut off any avenue to federal court there is exhaustion exemption. As to the latter, it's not enough that claimants would encounter potentially isolated instances of the inconveniences sometimes associated with the postponement of judicial review, or that their claims might not receive adequate administrative attention. The difficulties must be severe enough to render judicial review unavailable as a practical matter. Presently, is there any Medicare Part B physician provider, still standing, other than Dorothy Calabrese, M.D. who has had more severe difficulties:

- that hasn't been able to submit even one claim on any Medicare beneficiary since October

30, 2003 because they "should have known" the care wasn't covered?

- who was forced to choose letting all her employees go so as to be able to continue care unreimbursed for the established Medicare beneficiaries?
- who has worked seven days a week late into every night, including holidays, for now five years to keep their practice doors open to their established Medicare patients?
- who refinanced her only asset, her home, to be able to continue care for the established Medicare beneficiaries?
- who as a non-lawyer, was forced to invest extraordinary time and resources to learn applicable federal law and reasoning so as to withstand this intense opposition from the \$21 billion contractor's legal team, the CMS Region IX attorneys and the U.S. Attorney's office?
- who was told by the Medicare contractor to form a Political Action Committee (PAC) and buy her codes (certainly a cheaper alternative than this) because that is how it is now done?

Legislative branch intent for exhaustion

"Judicial review of executive action 'will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress.' "
[*Gutierrez de Martinez v. Lamagno*, H515 U.S. 417H, 424 (1995) (quoting *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967), *McNary v. Hai*

tian Refugee Center, Inc, H498 U.S. 479H, 496 (1991); Traynor v. Turnage, H485 U.S. 535H, 542 (1988); Michigan Academy, 476 U.S., at 670; Johnson v. Robison, H415 U.S. 361H, 373—374 (1974); Stark v. Wickard, H321 U.S. 288H, 309—310 (1944).]

Constitutional structure protects legislative& mandates

As Chief Justice Marshall wrote:

'It would excite some surprise if, in a government of laws and of principle, furnished with a department whose appropriate duty it is to decide questions of right, not only between individuals, but between the government and individuals; a ministerial officer might, at his discretion, issue this powerful process ... leaving to [the claimant] no remedy, no appeal to the laws of his country, if he should believe the claim to be unjust. But this anomaly does not exist; this imputation cannot be cast on the legislature of the United States.'"

[*United States v. Nourse, 9 Pet. 8, 28—29 (1835) (as quoted in Gutierrez de Martinez, supra, at 424)*]

Medicare providers leave Medicare patients because of CMS abuses

The Association of American Physicians and Surgeons has documented that these abuses

force Medicare physicians to turn away new Medicare patients, deliver less care to their Medicare patients, force their beneficiaries to sign Advanced Beneficiary Notices for care they know is medically necessary, retire early and leave Medicare entirely to avoid these CMS abuses.

Firing the Contractor is an insufficient remedy

Exhaustion is about preventing premature interference, to give CMS time to correct its own errors, to afford the parties and the courts the benefit of its experience and expertise, and to compile a record which is adequate for judicial review. Firing this Contractor's California Part A and B Medicare contract effective June 30, 2008 is a correct but wholly insufficient remedy. These systemic abuses antedate this Contractor. Furthermore, this Contractor is still left holding many other CMS contracts.

Physician providers and beneficiaries have a right to judicial review

The District Court misapplied p9 ¶3 *Mitchell v Occidental Insurance, Medicare* 619 F.2d 28 (9th Circuit 1980) Appellants have a right to judicial review. Supreme Court Justice Clarence Thomas has identified a bias he perceives that associations are given preferential standing for judicial review in these matters over physician

providers and beneficiaries, as in: *Bowen v Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). 476 U.S. 667. and *American Chiropractic Association, In. v. Leavitt* H431 F.3d 812 (D.C. Cir. 2005)

No Association for orphan illnesses

Minority-opinion allergy-immunology patients and other low-prevalence, low incidence patient subpopulations have no association representation by virtue of numbers, and as minorities cannot be discriminated against in this way.

**The DHHS DAB refused to hear the
“fraud”**

The District Court wrote p 9 FN 2: “there is no reason to believe that the DAB does not have authority to hear Plaintiff's allegations of fraud.”

This is not true. They said they wouldn't even know what to do. In the *United States v I. Lewis Libby*, US Prosecutor Patrick Fitzgerald was appointed because it's impossible for an agency of the executive branch to even give the appearance of adequately investigating itself under these circumstances.

**DE NOVO REVIEW OF
STATUTORY INTERPRETATION**

United States v. Cabaccang, 332 F.3d 622, 624-25 (9th Cir. 2003); United States v. Carranza, 289 F.3d 634, 642 (9th Cir. 2002); Beeman v. TDI Managed Care Svcs., 449 F.3d 1035, 1038 (9th Cir. 2006)

SCHIP Benefits Improvement and Protection - Act of 2000 Section 522

On 10-12-06 the DHHS DAB) ruled on our Joint LCD:

- i. there was a non-reimbursement of transfer factor LCD
- ii. that the relevant provisions were withdrawn by Dr. Bruce Quinn
- iii. that the LCD could not be used *sub rosa*

Furthermore, there was no LCD docket, which automatically reinstates reimbursement. The legislature thus conferred on Mr. Messer specific rights. Congressmen who authored the legislation articulated these rights in their letter to former DHHS Secretary Tommy Thompson:

If Congress had wanted beneficiaries to have the ability to challenge his or her own claim rather than the underlying policy, Congress would have only altered the existing claims adjudication process. However, the whole point of the Benefit Im

provement and Protection Act coverage provisions was to have a successful appeal by a single beneficiary create policy for others, much like the Supreme Court Rulings become the new law of the land."

[Letter from Bill Thomas (Chairman, Committee on Ways and Means), Charles B. Rangel (Ranking Minority Member), Nancy L. Johnson Chairman, Health Subcommittee) and Pete Stark (Ranking Minority Member) to Tommy Thompson and Tom Scully, September 27, 2002]

These rights are similarly affirmed in the Federal Register

"Review of an LCD or NCD requires examination of an entire policy, or specific provisions contained therein, and not just one claim denial. Therefore, such reviews may lead to changes that impact other beneficiaries if the policies are found to be unreasonable. A beneficiary, thus, may elect to pursue a claims denial through the claims appeal process, seek review of an LCD or NCD using the process in this final rule, or both."

[Federal Register: November 7, 2003 (Volume 68, Number 216)] [Rules and Regulations] (p 63691-63731)]

Appellants request de novo review of BIPA 2000 Section 522, to assure Mr. Messer and the other 25 LCD Appellant's rights are restored.

Medicare Modernization Act of 2003

42 USC 1395kk-1(d)(3)

The District Court wrote p 10 ¶3:

"While MMA did amend the Medicare Act, the 2003 amendments pertaining to carrier immunity did not go into effect until October 1, 2005. Because the conduct of the Plaintiffs took place in 2002, when Dr. Calabrese was audited, and in 2004, when NHIC terminated all reimbursement to Plaintiffs and wrote the alleged LCD to exclude care for Dr. Calabrese's patients, the amendments do not affect this case."

The Court's use of "alleged LCD" is improper because the DHHS DAB ruled there was an LCD. The Court misstates the dates, which all postdate October 1, 2005:

- a. On November 17, 2005, EDS - NHIC Carlos Rivera willingly and knowingly wrote a materially false statement to DHHS DAB Judge Richard F. Smith with the intention of obstructing justice.
- b. On May 6, 2006, Dr. Bruce Quinn willingly and knowingly wrote statement to DHHS DAB Judge Richard Smith which willfully and knowingly wrote materially false statements and made materially false entries to DHHS

DAB Judge Richard F. Smith with the intention of obstructing justice.

c. On March 28, 2007, the Medicare contractor launched a fraudulent retroactive liability and illegal US Treasury action, stating Appellants had lost the LCD appeal, which was not true.

The District Court wrote p 11 ¶1:

"Even if the amendments did not apply to the instant case, they would be of no avail to Plaintiffs because they do not address claims brought by third parties on their own behalf, but rather deal with a carrier's potential liability to the US for fraud and gross negligence."

"(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR. (A) IN GENERAL. – No Medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer, unless, in connection with such payment, the Medicare administrative contractor acted with reckless disregard of its obligations under its Medicare administrative contract or with intent to defraud the United States." 42 U.S.C. §1395kk-1(d)(2006) [Plaintiffs Response to Motion to Dismiss p 13 ¶ 33]

"Liable" is not restricted to "financially liable." "Or" is not "and." There can be no double standard: the "*fraud*" unequivocally represents "reck

less disregard under its Medicare administrative contract." And if I. Lewis (Scooter) Libby did not have sovereign immunity, neither does Dr. Bruce Quinn. In our Response to the Motion to Dismiss, Appellants referenced US District Court for the District of Columbia case: *US v. I. Lewis Libby: Criminal No. 05-394(RBW)* in 2007:

¶69 this Federal complaint is not about claims adjudication or monetary damages. It is about restoring the rule of law. The legal system suffers, because we don't know what the actual facts are because of the fraud and gross negligence of the Defendants. Plaintiffs rely on the legal system to function properly. Plaintiffs ask for remedies that demand accountability so this can never happen to us again.

¶70 I. Lewis Libby made false statements to a government agency and he obstructed justice. He was found guilty of this and perjury and sentenced to jail. The sentence was commuted but he had to pay a fine and do community service. He was disbarred. This remedy did not strictly redress the harm. It was designed to stop civil servants from harming the system by making false statements, just as Plaintiffs want to stop Dr. Bruce Quinn from harming the system by making false statements and entries and obstructing justice.

¶71 US Attorney Patrick Fitzgerald said when the verdict came in the Lewis Libby case which also involved false statements and ob-

struction of justice: "We don't comment -- we try and treat everyone the same under our legal system. No one's above the law, no one gets less protection than the law. . . Our comments, in summation, were directed to responding to an argument by the defense that they fairly made. We fairly responded. And our point was that Mr. Libby did not tell the truth to the system. And when someone doesn't tell the truth to the system, everyone suffers. The legal system suffers, because we don't know what the actual facts are. And, frankly, lots of other people suffer since, when you don't know what the truth is, people draw all sorts of conclusions. So all we'll say that Mr. Libby, by lying and obstructing justice, harmed the system. And that was something serious. And that's the point we made to the jury, and obviously the jury agreed factually."(emphasis added)

"When you don't know what the truth is" - the saddest part because until now, the Contractor willingly and knowingly made sure that the DHHS DAB and the Federal District court didn't know what the truth was.

The CMS interference in Appellant's practice violates the Medicare Act:

- i. causes preventable premature morbidity and mortality – irreparable harm
- ii. forces Medicare physician providers to practice in fear and turn away or do less than the standard of medical care with patients such as those with concomitant psychiatric illness,

those who have been physically and sexually abused, those who have legally immigrated from oppressive regimes and so forth. They are extremely vulnerable to sub rosa policies such as the Contractor "secret questionnaires."

iii. forces every decision made in clinical practice of medicine on every Medicare patient to meet a forensic standard. Majority-opinion allergists don't have to order unnecessary additional diagnostic tests. This doubles or triples the cost of care for the minority-opinion patient.

iv. hurts patients who have qualified for SSI and Medicare because they're medically uninsurable, sick and poor. Some of these patients are very elderly. They fear this Medicare contractor will target their Social Security benefits or target their other physicians.

v. destroys diversity of medical opinion so as to socially engineer the practice of medicine.

vi. violates basic US public health policy where Medicare physician providers must report and treat diagnoses and symptoms of low-prevalence and low incidence populations including those with chemical sensitivity.

vii. abrogates basic medical practice tenets and ethics that Medicare physicians cannot abandon medically necessary ongoing successful medical care of their Medicare beneficiaries.

DE NOVO REVIEW OF
CONTRACT INTERPRETATION

Milenbach v. Commissioner, 318 F.3d 924, 930
(9th Cir. 2003)

A. Contract designates the Medical Director will decide who lives or dies:

Appellants are third-party beneficiaries of the Medicare contract. The California Contractor Medical Director, Dr. Bruce Quinn, by contract, is exclusively designated as the individual who determines medical necessity – who lives or dies. . . who suffers and who receives care. There are no contractual safeguards to assure that the Contractor Medical Director is an honest broker. Meanwhile, the contract has extensive requirements for printing on double-sided recycled paper and guidelines for lifeguards and dry cleaners. It's wholly insufficient for Medicare laws to reference "equity and good conscience" (H42 U.S.C.S. § 1395gg(c)H) without accompanying clear contractual mandates so the Contractor Medical Director shall act with "equity and good conscience."

B. Contract loopholes allow the Contractor to avoid FOIA and other laws

With respect to Dr. Quinn, the contract (attachment 1.5 p 2 of 16 of the EDS – NHIC California contract states: "Independently and not as an agent of the government the Contractor shall furnish all of the necessary services qualified personnel, material, equipment and facil-

ties not otherwise provided by the government as needed to perform the requirements of the Statement of Work." This Contractor's attorney argued this means they don't have to comply with FOIA and other laws, so they don't even have to provide the LCD docket, their medical expert opinions and so forth. This obstructs justice. BIPA 2000 Sec 522 requires Appellants know exactly what the Contractor did or did not consider and provide rebuttal and further proof that wasn't considered before Appellants can even be granted standing to file the LCD Appeals by the DHHS DAB.

**DE NOVO REVIEW OF
CONSTITUTIONALITY**

United States v. Carranza, 289 F.3d 634, 643 (9th Cir. 2002)

A. Violation of the due process clause of the Fifth Amendment

On 03-28-07, The Medicare contractor independent hearing office used the LCD sub rosa and denied a hearing that Appellant had waited for 2 years that the Contractor kept delaying. The Contractor and the Federal Court denied Appellants the redetermination hearing. Due process demands impartiality on the part of those who function in a quasi-judicial capacity, such as the Medicare contractor hearing officer involved in our case. There is a presumption that these officers are not only unbiased but that the Medi-

care contractor did not willingly and knowingly obstruct justice by:

- (1) falsifying, concealing, and/or covering up by any trick, scheme, and/or device material facts
- (2) making any materially false, fictitious, and/or fraudulent statements and/or representations
- (3) making and/or using any false writings or documents knowing the same to contain materially false, fictitious, and/or fraudulent statements and/or entries.

But this is what happened to Appellants that violated the due process clause of the Fifth Amendment. Furthermore, the issue is not moot because we face more Contractor-appointed independent hearings.

DE NOVO REVIEW OF FEDERAL RULES

United States v. Matley Family Trust, 354 F.3d 1154, 1159 n.4 (9th Cir. 2004)

A. Majority-opinion specialists given competitive position and dominance

Appellants challenge the validity of specific CMS processes and policies that give majority-opinion allergist-immunologists and their Medicare beneficiaries a competitive position and dominance in their longstanding turf war against the minority. [*Bowen v Michigan Academy of Family Physicians*, 476 U.S. 667 (1986)]

Bowen v Michigan Academy hasn't been overturned and will withstand any Shepardizing with respect to subspecialty anti-competition turf wars not rationally being related to any legitimate purpose of the Medicare statute. Two decades later, *ACA v. Leavitt* 2003 affirms this: HHS Secretary has stated the Medicare Act was not "intended to protect the competitive position of chiropractors or to limit the markets available to licensed medical doctors."

The Medicare contractor shows extreme bias in choosing majority-opinion subspecialists to review minority-opinion subspecialists. Why did the Medicare contractor refuse to contact two Daubert-qualified transfer factor immunomodulatory therapy experts (one Emeritus UCSF and a member of the California Medical Board, the other a Stanford Medical School allergist-immunologist since 1964)? Instead they chose Lewis J. Kanter, M.D. Dr. Kanter knew in advance that Dr. Calabrese sees patients he cannot successfully treat and she can get them well. One of his former patients, who he himself admitted was too sick for him to help, provided her declaration to Dr. Kanter in advance of our OMHA hearing and it is included in our 198 OMHA exhibits. She was so debilitated she had to quit her public school first grade teaching position. She saw a total of three majority-opinion allergist-immunologists and remained chronically ill. After receiving custom preservative-free antigen immunotherapy

and transfer factor immunomodulatory therapy, she made a miraculous recovery and is now normal. Why would any majority-opinion allergist-immunologist believe she was only entitled to Medicare reimbursement for majority-opinion care, when that care did not work for her? Why would Dr. Calabrese repeat majority-opinion allergy-immunology care when that had already failed three times? The Contractor chose a non-Daubert qualified majority-opinion allergist-immunologist, which is anti-competitive and is not the legal standard.

B. Applicable Medicare rules need enforcement consistency provisions

Appellants challenge the validity of applicable CMS processes and policies, particularly as implemented, which make no provisions for enforcement consistency.

JUDICIAL ECONOMY

A. Appellants were forced to file a second Federal case on new fraud

Appellants filed a second Federal case SACV07-1444 AHS on 12-14-07 re: entirely new Appellee fraud, gross negligence and reckless disregard. On December 6, 2007, Appellees a) committed perjury, b) made materially false statements, c) made materially false entries, d) made and/or used false writings and/or documents knowing the same to contain materially false, fictitious, and/or fraudulent statements or entries and e) obstructed justice to Judge Ri-

chard Gould in our OMHA appeal #1-185294748. Administrative remedies have been exhausted in SACV07-1444 AHS. This only underscores why earlier judicial review was so critical. The "*fraud*" only escalated.

Furthermore, Appellants need SACV07-1444 CJC-RNB to reinstate active access to Federal court ex-parte protection that we lost when the "Order Granting the Motion to Dismiss" was granted on 09-25-07. For example, on 07-30-07, Appellants were forced to file an ex parte application for a "Preliminary Injunctive & Declaratory Relief enjoining Appellees from Making More False Statements and Entries to the U.S. Treasury Department, other Government Agencies & Courts." In response to our ex parte, Appellees immediately withdrew a totally fraudulent collection action which would shut the doors to Appellants' allergy-immunology practice and left her bankrupt. No other remedy was available to stop this fatal blow except by Federal District court ex parte. We continue to be active targets of this rogue Medicare contractor and have already filed an ex parte application in this second case and need protections.

B. Appellant was forced to file another LCD appeal

On October 31, 2007 Appellant was forced to file another LCD appeal #C-08-72, DHHS DAB Judge Keith W. Sickendick because the rights Appellants won in the Joint 2005 LCD appeal are denied by CMS and this Federal case was

derailed with the Order Granting Defendants' Motion to Dismiss. This is another collateral and totally unnecessary case, because the original Federal District Court case should have addressed these collateral issues.

C. Appellants have been forced to file FIVE Medicare lawsuits in 2 years Appellants so have now have been forced to file:

- i. two Federal lawsuits: SACV06-1217 CJC and SACV07-1444 CJC-RNB
- ii. two LCD appeals: #C-050183 and #C-08-72
- iii. one OMHA appeal: 1-185294748.

D. CMS requires Appellant file hundreds of individual beneficiary appeals

CMS John Warren wrote to DHHS DAB Judge Richard Smith that we must do individual beneficiary appeals on every single patient in perpetuity, in contradiction of the LCD Appeal statute. Our individual appeals filing includes 302 peer-reviewed full citations from over 90 top academic medical centers totals 5,000 pages. Our printing costs alone for an individual appeal costs are over \$750 plus the physician and beneficiary time required to go to the hearing. And we can ask to be reimbursed years later for the \$164.90 Medicare pays for the two-hour new patient appointment and associated hours of record review. The majority-opinion allergist-immunologist is paid the \$164.90 in two weeks by direct bank deposit for performing a much less intensive evaluation with no comprehensive record review and no questions.

DENIAL OF HEARING

On September 25, 2007, the District Court wrote in the "Order Granting Defendants' Motions to Dismiss Plaintiffs' SAC" (filed 08-20-07) p 1¶ 1: "The Court finds this matter appropriate for disposition without hearing."

A. Haines v. Kerner, 404 U.S. 519 (1972)

The standard in a Motion to Dismiss is that the Appellants case was to be considered in its most favorable light. To meet that requirement, the minimum should have been the opportunity for our scheduled hearing. Court input and an opportunity to amend our complaint as the Supreme Court ruled in Haines v. Kerner, would have led to substantial justice. The US Supreme Court has unanimously ruled that a pro se complaint, "however inartfully pleaded," must be held to "less stringent standards than formal pleadings drafted by lawyers" and can only be dismissed for failure to state a claim if it appears "beyond doubt that the Appellant can prove no set of facts in support of his claim which would entitle him to relief."

B. Bell Atlantic v Twombly 127 S.Ct. 1955, 1974 (2007)

Dismissal of a complaint for failure to state a claim is not proper where a Appellant has alleged "enough facts to state a claim to relief that is plausible on its face."

C. Doe v United States, 58 F.3d 494, 497 (9th Circuit 1995)

In keeping with this liberal pleading standard, the district court should grant the Appellant leave to amend if the complaint can possibly be cured by additional factual allegations. A court reviewing a motion to dismiss must construe a complaint in the light most favorable to the Appellant, the allegations thereof being taken as true. *North Star Int'l v. Arizona Corp. Comm'n*, 720 F.2d 578, 580 (9th Cir. 1983).

Supreme Court Justice Stephen Breyer has said that only the judiciary is unique among the three branches of government in being able to protect the minority from the majority.

Respectfully submitted on January 1, 2008

/s/ Paul Messer

/s/ Dorothy Calabrese, M.D.

I - MULTIPLE CHEMICAL SENSITIVITY SYNDROME

Center for Medicare Services
National Heritage Insurance Corps
1055 West Seventh Street
Fifth Floor
Los Angeles, CA.

MEDICAL ADVISOR'S

OVERALL SUMMARY

Dr. Calabrese is giving transfer factor for multiple chemical sensitivity syndrome. There is no medical basis(supportive in the medical literature) to support this treatment.

Dr. Calabrese lists multiple articles regarding transfer factor, but again nothing published in the literature to support its use in patients with 'multiple chemical sensitivity syndrome."

Transfer factor should not be reimbursed!

I - MULTIPLE CHEMICAL
SENSITIVITY SYNDROME

There is also no medical basis for the diagnosis of Multiple Chemical Sensitivity as per American College of Allergy Asthma and Immunology.

MEDICAL ADVISOR SIGNATURE

DATE: 2/26/03

[Dr. Bruce Quinn, CMD of NHIC refused to identify this anonymous reviewer to Michael Marquis, head of CMS FOIA, claiming NHIC's medical experts have a privacy exemption.]

J - OTOL CLINICS OF N.A.

Otolaryngologic Clinics of N America 36
(2003)917-940

Approaches to testing for food and chemical sensitivities

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EXCERPT

The term allergy describes diseases in which immune responses to environmental antigens cause tissue inflammation and organ dysfunction. Allergy is not restricted to inhalant pollens, dusts, and molds. In fact, a wide variety of molecules is capable of reacting with antigen-presenting cells and lymphocytes to elicit allergic reactions. Unlike patients seen after anaphylactic response to foods or following acute toxic chemical exposures, most patients with food or chemical sensitivity are not acutely ill, and the origin of their chronic symptoms may not be obvious. Recognition that food or chemical exposure is an issue requires specific questioning, testing, and, above all, the suspicion that these substances might be playing a role.

This article reviews the clinical patterns of food and chemical sensitivity and discusses diagnostic methods for determining the existence and magnitude of allergy or sensitivity to either foods or chemicals.

Clinical patterns of food allergy

Although food allergy has been known since ancient times, Herbert Rinkel [1], a classically trained allergist, first clearly described the two distinct clinical patterns of food allergy.

Cyclic food allergy

By 1934, Rinkel was using oral food challenges to supplement skin tests in the evaluation of food-sensitive patients. He reported many patients who exhibited nonanaphylactic symptoms that occurred hours to days after food ingestion and that could be temporarily relieved by eating more of the sensitizing food. Previous researchers [2,3] had recorded this type of food sensitivity, but Rinkel described the production and resolution of symptoms as phases of a single process, which he called cyclic food allergy. Between 1936 and 1964, Rinkel [1,4-9] fully developed this concept and showed that cyclic food allergies had distinct clinical differences from anaphylactic food allergies. Subsequently, some of the molecular mechanisms behind these clinical behaviors have been discovered. Anaphylactic food allergies definitely are caused by type I Gell and Coombs IgE-mediated reactions. Cyclic food allergies seem to be caused by mixed immune reactions, of which type III immune complex mechanisms are probably most important

[10]. This topic has recently been reviewed [11,12].

Anaphylactic or fixed food allergy

Type I immediate food allergies are frequently severe, sudden, and unexpected. In many situations, the diagnosis is obvious from the history. The reaction, however, may occur during a meal during which many foods are consumed, so that no one food can be held responsible. In other cases, the reaction may be primarily a late-phase cellular reaction, with asthma, eczema, or chronic ear or nasal disease as the major symptom; again, no one food can easily be identified as causative. In these cases, as in cyclic food allergy, diagnostic tests usually are required to identify candidate foods that may be responsible. Clinical patterns of chemical sensitivity Environmental chemical exposure Chemicals, synthesized by geologic processes, have always been part of the human environment. Furthermore, food plants typically contain more than 500,000 different biochemicals [13]. These chemicals, some nutritious and some toxic, must be metabolized, detoxified, stored, or excreted, and animals have evolved the necessary biochemical capability to do so. Technology has changed the human environment. Since the industrial revolution, truly novel chemicals and enormous quantities of previously rare chemicals have entered the environment, and the process is continuing. Since World War I, more than 35,000 chemicals have been in common use, and about

3000 new chemicals are introduced each year [14], in amounts of about 1 ton of chemicals produced per person per year. These xenobiotics are molecules that are foreign to the body, and they are now detectable in all ecologic niches. The human capacity to detoxify xenobiotics is not infinite and, when overwhelmed, leads to illness. Further, even if the detoxification capacity is not exceeded, the process has metabolic costs and can still lead to disease from reaction by-products. Finally, some xenobiotics are resistant to detoxification and persist in the body, stored in cell membranes where they influence membrane fluidity, permeability, and cell functions. Some xenobiotics are sources of destructive free radical production, whereas others interact synergistically, causing cell injury at lower concentrations than a single chemical alone. Most xenobiotics have not been studied. Because of global air and ocean circulation patterns, everyone is ultimately exposed to all pollutants, although individual doses vary. The longterm trend of increasing pollution from the industrial revolution is clearly shown by polar ice core analyses [15]. Today, in urban areas, volatile organic xenobiotics may exceed levels of naturally occurring terpenes and methane. Because of energy-efficient construction, indoor air is often more heavily polluted than outside air. Major airborne xenobiotics are carbon monoxide, nitrogen oxides, sulfur oxides, ozone, halogens, volatile organic chemicals, diesel exhaust particles, smoke particles, and dusts. Carbon

monoxide inactivates the cytochrome oxidase detoxification system. Ozone is immunosuppressive and inactivates the mixed-function oxidase detoxification system. Nitrogen oxides, sulfur oxides, halogens, and ozone consume antioxidants, thus depleting the ability to neutralize free radicals. These gases are also synergistic with allergens in causing respiratory tract inflammation. Particulates are known to contain potent carcinogens, to initiate inflammation, and to stimulate allergies. Although many xenobiotics are present in low concentrations, they are efficiently trapped and concentrated in cell membranes when inhaled, because of their high lipid solubility. Because of this accumulation, individual body burdens of some xenobiotics may become large enough to produce illness even in the absence of any large toxic exposure.

Mechanisms of chemical injury

Three basic types of clinical illness are observed after xenobiotic chemical exposure: acute toxicity, chronic toxicity, and chemical allergy. Detoxification reactions occurring in the liver are involved with all three types of illness.

Hepatic detoxification

The liver is capable of detoxifying a wide range of xenobiotics by biotransformation to less toxic substances that can be either metabolized or excreted [16]. The principle mechanisms

are oxidation, reduction, hydrolysis, methylation, and conjugation with peptides, amino acids, sugars, or inorganic ions. Nonconjugation reactions usually result in smaller molecules that can enter cellular metabolism. Oxidation or reduction reactions are carefully compartmentalized within the hepatocyte, in close association with enzymes and cofactors capable of neutralizing reactive intermediates and quenching free radicals. During biotransformation reactions, some highly reactive carcinogens or mutagens are formed [16] and may later cause cancer. Other reactive metabolites may act as haptens and cause allergic sensitization. Chemicals that can be conjugated are excreted in urine or bile. Aromatic or halogenated hydrocarbons are often resistant to detoxification and accumulate in cell membranes, where they are an ongoing source of free radical production. Patients who are unusually susceptible to chemical injury may be deficient in some detoxification system components [17].

Acute toxicity

Acute toxicity reactions occur with relatively few chemicals [18] and are normally easily diagnosed by history. Some (ethanol, aspirin, acetaminophen) are household products, whereas others (cyanides, chromates, organophosphorus insecticides) are used in industry or agriculture. Acute injury occurs when the detoxification systems are overwhelmed by exposure to a large quantity of chemical. A common mechanism of acute injury, triggered by many chemicals, oc

curs from uncontrolled oxidation and free radical production. The free radicals damage cell macromolecules and cause cross-linking, which impairs cell functions, causes mutations, and can prevent cell division. Altered cell immunogenicity may also result. As a consequence of acute free radical injuries, survivors may develop autoimmune disease, neoplasia, or progress to chronic chemical illness. Extensive acute oxidative injury may cause hepatic failure because of the concentration of free radical production in that organ.

Chronic toxicity

Chronic toxicity may take either of two forms: constant or repeated lowlevel exposure, or residual effects after an acute exposure. Chronic and acute toxicity share similar pathophysiology, but in the chronic state detoxification mechanisms are adequate, resulting in a state of compensation. In the compensated state, however, reserves are depleted, free radicals, haptenes, and carcinogenic by-products are continuously generated, and resources are shifted to maintain the detoxification pathways, so that the organism is left less able to handle other stresses [19]. There may also be adverse effects of chronic chemical exposure on specific tissues; for example, the triggering of autoimmune glomerulonephritis from mercury exposure [20], central nervous system toxicity

from styrene, immune dysfunction from dioxin, and reproductive toxicity from 1,3-butadiene [21].

• **Allergic hypersensitivity**

Allergic hypersensitivity is the third type of clinical result from chemical exposure and occurs through the formation of protein-bound haptens and the development of IgE-mediated immediate allergic sensitization. Molecules smaller than penta-peptides do not normally react with antigen-processing cells. Chemically reactive haptens easily bind to carrier molecules that will react with antigen processing cells, however, and lymphocytes sensitized in this way can produce antibodies or sensitized cells that react with free chemicals [22]. This mechanism is the mechanism for most drug allergies and also for reactions to mercury [23], latex [24], and formaldehyde [25]. Hapten sensitization is common: from 2% to 15% of allergic emergencies are caused by chemicals [26]. Some chemical allergies are readily recognized, for example, reactions to latex or to nickel. Other chemical allergies are difficult to identify, for example, asthma caused by toothpaste flavoring [27]. Delayed chemical allergic reactions may also occur, especially with plastic resins [28], nickel, and formaldehyde [26]. All four Gell and Coombs classes of hypersensitivity reactions to a chemical may coexist. As with cyclic food allergy reactions, these complex immune reactions to chemicals may be difficult to recognize, and

identifying the responsible chemical may be difficult.

Importance of history in food and chemical cases

Suspicion of food or chemical sensitivity depends primarily on taking a good history. The history helps select patients who require testing and may also identify which type of sensitivity is likely to be involved and which foods or chemicals are likely to be responsible. An important part of this history is an assessment of the total allergic load.

Patient load assessment

Chemical toxicity, chemical allergy, and food allergy may occur together in a person who has typical inhalant rhinosinusitis or asthma symptoms. In these patients, all possible confounding factors must be considered together as part of the total allergic load. A large total allergic load exists when a patient frequently contacts such quantities of allergens that a significant amount of allergic mediators is always circulating in the body. The addition of only a small additional allergen challenge, for example inhaling a whiff of perfume or eating a small snack, is enough to raise the mediators to symptom-producing levels. After inhalant allergens, other contributors to the total allergic load are foods, drugs, food additives, xenobiotic chemicals, and the patient's nutritional and psychologic health. The common factor linking all of these is their effects on the generation or neutralization of free radi-

cals and their contribution to physiologic stress. The allergic load should be assessed during the initial interview when the possibility of allergy is suggested by personal or family history or by physical findings. Because of the potential for treatment failure if major allergen or chemical contacts are not recognized, the total load concept should be kept in mind when selecting substances to be tested.

Suspicion of food allergies

Suspect food allergies where there were childhood symptoms of formula intolerance, colic, gastroesophageal reflux, severe diaper rashes, or gastrointestinal symptoms without a specific pathologic diagnosis or when foods were or are intentionally avoided. Food allergy also should be especially considered in any chronic disorder in which allergy could play a role: asthma, recurrent bronchitis, hyperactivity, otitis media, rhinosinusitis, eczema, or migraine. Chronic constitutional symptoms such as fatigue, poor-quality sleep, nonspecific pruritis, dysequilibrium, headaches, frequent respiratory illnesses, and the so-called "many syndrome" (many complaints, many physicians, many failed treatments) should also raise suspicion of food allergy. Children often seem to outgrow these problems as they consume less food per kilogram of body mass, but frequently they retain significant sensitization that can cause symptoms as adults. The presence of any of these symptoms or conditions should suggest food allergy in the differential diagnosis, but it

is important to remember that food allergy is not the only possible explanation. Potentially serious alternate diagnoses must always be evaluated (eg, excluding a brain tumor as an explanation for headaches or hepatitis C as a cause of fatigue).

Ingestion history (diet diary)

Cyclic food allergy produces symptoms proportional to the quantity and frequency of food ingestion, and symptom masking may occur when eating more food temporarily improves the adverse reaction from a previous ingestion. Deciphering symptoms is most easily done by the use of a 2-week food diary. Use of a diary allows targeted testing for only the foods that are likely to be significant and thus avoids excessive testing. It is important that all items consumed be recorded, including medications, vitamins, herbal remedies, beverages, chewing gum, junk foods, and candies. Emphasis is placed on recording actual diet habits and on being truthful. The patient should record the time of ingestion, the time any symptoms are observed, and any cravings or improvement in symptoms. Entries should be made throughout the day, instead of waiting until the end of the day. The diary is analyzed for frequently eaten foods and any symptom pattern. Most people regularly eat only about ten foods, but this limited diet is seldom recognized because of the many different ways to combine foods. The hidden foods (corn, milk, soy, wheat, and yeast) that are used in

processed foods are an almost universal problem. Allergic cross-reactions between closely related foods further reduce variety. For example, persons who are allergic to wheat often also react to rye and barley. Clinically suspect foods are those eaten at least twice weekly; those eaten daily are especially suspect. Craved foods or foods eaten during the night are also highly suspect. Chemical ingestants should also be evaluated. In some patients, even minute amounts of food additives may be significant, and these sensitivities are not likely to be discovered without use of a diary. For example, in one urticaria study, chemical food additives were found to be the triggering agent for 26% of patients [29].

Suspicion of chemical sensitivities

Symptoms caused by chemical exposure are protean: almost any symptom is possible. Symptoms that should always raise suspicion of chemical toxicity include unexplained chronic pain, decreased cognitive function, vasculitis, and unexplained fatigue. As with foods, the first step in evaluation is always to take a complete history [30]. Often the history will reveal a prior exposure to a class of chemicals. Specific signs or symptoms may also suggest organ dysfunction, leading to suspicion of exposure to certain chemicals. Environmental chemical contacts at work, home, or during recreation should be sought. Because chemicals may stay in the body for life and continue to exert effects, past exposure is always relevant. Specific questions must

be asked, because individuals may not volunteer exposure to termite-treated homes, mobile homes, latex, toxic waste sites, or industrial emissions near former residences. Sometimes, reviewing lists of occupational chemicals with the patient may trigger recognition [31]. Also, ask about skin or inhalation contact with chemicals. The type of buildings in which people work or live may also be important. Closed buildings potentially expose people to outgassing chemicals, mold, bacteria, and dust [32,33]. Specifics of the home and work environments, including building age, heating, cooling, and cleaning systems, presence of a basement, new insulation, ventilation, presence of water leaks, a moldy or musty smell, and chemical use or storage, must be evaluated. The presence of many plastics, for example in mobile homes, or recent remodeling or carpet installation is often significant. Recreational activities such as golf, painting, wood or metalworking, and restoring cars can also involve substantial chemical exposure. Metal exposure is another potential problem. Jewelry contact allergy is normally suspected by the restricted location of the skin lesions; however, allergy caused by ingestant or contactant metal exposure or by implanted metal alloy prostheses also occurs [34,35]. Allergy or toxic effects from other implants and appliances, such as dentures, hearing aids, eyeglasses, plastic implants, and dental bridgework or amalgams [20], may also occur.

Summary

Testing for food and chemical sensitivities usually becomes necessary as part of the evaluation of otolaryngology patients who have chronic illness. The more complex the patient, and the more recalcitrant the problem is to treatment, the more likely it is that allergies, and especially food or chemical sensitivities, are involved in the pathogenesis of the illness. Failure to consider all major allergen contacts, including foods and chemicals, can lead to inadequate therapy. Similarly, failure to understand total allergic and oxidant load and the effects of chemical toxicity can lead to inappropriate or ineffective treatment. Clinically, food allergies occur in two different types: immediate, anaphylactic, fixed reactions and delayed, chronic, cyclic reactions. Different test methods have been developed for the two types. Fixed food allergies can be safely and efficiently detected by *in vitro* specific IgE or histamine release tests. Cyclic food allergies are best detected by either oral food challenges or by the IPDFT test. Choosing the best test for a particular patient requires a clear understanding of the two food allergy types and how their clinical presentations differ. Other tests for food allergies are compared and contrasted with these primary tests. Chemical sensitivity also occurs in two different clinical types: allergic, and toxic. True allergy to chemical haptens, either type I, IgE-mediated, or type IV, delayed hypersensitivity, occurs with significant frequency but is often unsuspected.

Chemical toxicity can be caused by the aftereffects of an acute exposure or as a result of chronic, low-level exposure, but is even more frequently unsuspected and will not be diagnosed without a high index of suspicion. Both types of chemical sensitivity need to be addressed in any patients who have either a high allergen or chemical exposure load [105]. Either *in vitro* or *in vivo* tests can be used for chemical allergy detection; the advantages of each are outlined. Chemical toxicity screening tests are available and useful but do not detect all possible toxicants. Definitive toxic chemical tests usually require specialized laboratory facilities and expert consultation, for which possible sources are specified. The most important point in testing for food or chemical sensitivity is to be aware that food or chemical sensitivity can be contributing to a specific patient's clinical problems. Only then can appropriate investigations be undertaken to understand and then, perhaps, to intervene successfully in that illness.

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Head & Neck Surgery, P.C.
65 Cedar Street, Hyannis, MA 02601
(508) 790-0611

J - OTOL CLINICS OF N.A.

Education:

U. C. Berkeley; Molecular Biology, M.A., 1972

University of Rochester; M.D., 1976

Surgery Internship, 1976-1977 UCSD

Otolaryngology Residency, 1977-1981, UCSD

Board Certification: Otolaryngology-Head & Neck Surgery 1981

Memberships:

Fellow, American Academy of Otolaryngologic Allergy

Member, American Academy of Facial Plastic and Reconstructive Surgery

Member, American Medical Association

Hospital Privileges:

Department of Otology and Laryngology, Harvard University

Massachusetts Eye & Ear Infirmary (Boston)
Associate Surgeon Cape Cod Hospital (Hyannis, MA) Chief of Otolaryngology

Rehabilitation Hospital of the Cape & Islands, Consultant

Academic/Teaching Experience:

1986-Present: Director, American Academy of Otolaryngic Allergy - Basic & Advanced Allergy

1985-Present: Clinical Instructor, Harvard University

1983-1996: Plastic Surgery Surgical Teaching, Mass. Eye & Ear Infirmary, Boston

1970-1971: Teaching Assistant, Molecular Biology, University of California, Berkeley

J - OTOL CLINICS OF N.A.

Honors:

2003: Sam Sanders award for Clinical Allergy Research, AAOA 2003

2002-2003: President, American Academy of Otolaryngic Allergy [AAOA]

1998-2001: President, International Society of Otorhinolaryngologic Allergy & Immunology

1996: Honor Award, American Academy of Otolaryngology-Head & Neck Surgery

1994: Golden Apple Award for Teaching Excellence, AAOA

1967-1972: NIH Training Grant, U.C. Berkeley

Memberships:

Fellow, American Academy of Facial Plastic & Reconstructive Surgery.

Fellow, AAOA

Chairman of Scientific Affairs and Research Committee member,

Past Council Member and Director of Continuing Medical Education

Fellow, American Academy of Otolaryngology-Head and Neck Surgery.

Allergy-Immunology & Environment Committee

Fellow, American College of Surgeons

American Medical Association

Massachusetts Medical Society.

Past Council Member.

Massachusetts Society of Otolaryngologists,
Past Board of Directors

K - TH1 - TH2 DEFECT

CMB DETERMINES MEDICALLY NECESSARY CARE

I have been a duly licensed physician in the State of California since 1979. The California Medical Board [hereinafter CMB] and the State of California determine what is medically necessary in my medical practice. The CMB reviewed my protocols, records, did onsite inspections of our lab and practice, reviewed the relevant medical and scientific literature on TF. CMB physicians, Dr. Raichlin and Dr. Franklin were extremely complimentary of my practice and specifically stated my protocol would be considered the protocol for the State of California.

The CMB is structured so as to be independent and entirely fair so there is no conflict of interest in their decision making. The CMB physicians are retired surgeons and board specialty panelists who do not participate in medical turf wars. It has been my privilege to practice medicine in this State because of the CMB, which has been to my office, reviewed the patients care, the lab and the protocols and found the preservative-free antigen immunotherapy [hereinafter PF antigens] and TF as reasonable and medically necessary for our families.

In the 27 years that I have been practicing in this obscure area of allergy-immunology, we have never received a final denial of reim-

K - TH1 - TH2 DEFECT

busement based on medical necessity, or any other reason. The State Insurance Commission honors the position of the CMB.

The Medicare contractor and ERISA regulated insurance benefit administrator medical directors are not regulated by the State Insurance Commission, but that does not give them the authority to stick their finger in the eye of the CMB, disregarding their position.

It is unequivocal that Medicare contractor and ERISA regulated insurance benefit administrator medical directors are not independent in the same way that the CMB is. Eliminating medically necessary care for patients with orphan illnesses can be leveraged for favorable financial gain in contract renegotiations with CMS or the private corporation providing health care benefits under ERISA.

Under Medicare and ERISA, patients with orphan illnesses have no real protection for how medical necessity is determined outside of Federal questions. For purposes of full disclosure, my professional interest in this area of allergy-immunology is a direct result of having this hereditary illness in its most catastrophic form. At age 26, when I had just completed both my medical training at Columbia College of Physicians and Surgeons and associated three-year residency, I was given an unequivocal death sentence from three top California academic centers. This care saved my life from terminal asthma and multisystem allergic-

K - TH1 - TH2 DEFECT

immune disease. I have buried two of my boys with this illness.

So it is very personal for me that anyone in my profession would attempt to hide behind an unintended consequence of federal law – be it Medicare or ERISA to try to discriminate against our families for who they are genetically. It has never been Congressional intent for physicians under Medicare nor ERISA to preempt the state's discretion to determine medical necessity in this way. Medical necessity is predicated on real science not political science. The Courts have affirmed this. We seek timely reaffirmation for our orphan patient group.

This declaration sets forth basic clinical medical and basic science information well documented in the medical literature and clinical practice for the past sixty years.

This orphan group of refractory patients has:

1. extensive allergies, including allergic hypersensitivity to chemicals, and abnormal cell mediated immunity - delayed type hypersensitivity.
2. an underlying pathophysiology, which is a combined Th1 – Th2 immunoregulatory defect
3. clearly dramatic therapeutic response to TF (a specific Th1 therapy) and PF antigen (a specific Th2 therapy).

K - TH1 - TH2 DEFECT

CLINICAL

Figure 1 - Combined Th1-Th2 cytokine defect clinically presents outside the usual spectrum of illness

1. The majority of patients have been referred by their physician, including allergist-immunologists, friend or relative. Because this is not a common clinical diathesis, the patient group is small and hails from many states and many California counties.
2. There is a distinct hereditary distribution to this patient group.
3. There is >85% concomitant hypothyroidism, goiter and/or Hashimoto's thyroiditis (Th1 mediated).
4. They have sought out academics and frequently have had comprehensive work-ups. They typically have tried very limiting allergy diets, allergy shots, allergy medications, strict environmental controls and so forth. They do not respond the way their allergist's other patients respond.
5. They typically have significant involvement of two or more organ systems as well as disabling constitutional symptoms which has caused them to lose the ability to perform basic activities of daily living, including self-care.
6. Some have had recurrent infection most typically viral infections with secondary bacteria

K - TH1 - TH2 DEFECT

and some have some mucocutaneous candidiasis. They do not present with the common opportunistic infections of severe primary immune deficiency or severe combined immune deficiency.

7. As their allergies progress they have a disproportionate percentage of food, mold and chemical allergies.

8. Many of the patients report sensitivity to pollutant effects that are normally well tolerated by healthy individuals, but they are not toxicology patients.

9. Except for blood relatives of established patient families, all patients are carefully screened to make sure the differential diagnosis is correct before patients are even accepted to the practice.

10. After 60-90 days of institution of immunotherapy, responsive patients will start to see definitive clinical changes, which almost peak at 1 year. The typical program is three years because that is what gives the best long term results. A certain number of patients will break through at 5, 10 or even 15 years and need another course of immunotherapy. About 10%, the severely impacted patients, will need long term care.

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Combined Th1-Th2 cytokine defect clinically preser

GENOTYPE

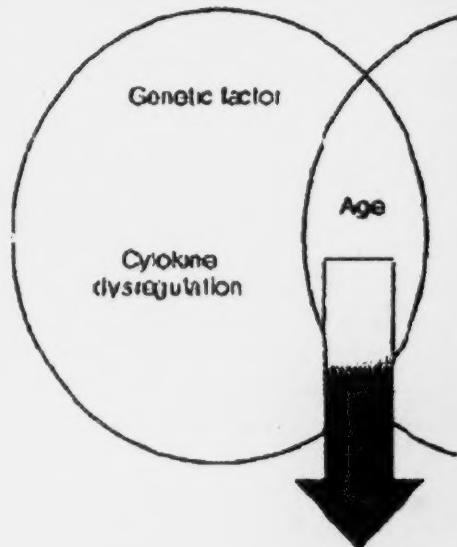
family members with:
allergies, immune problems,
immune mediated inflammatory
disease, hypothyroidism
including Hashimoto's thyroiditis
(but not Graves disease)

PHENOTYPE

acute & chronic symptoms
relapsing & remitting symptoms
progressive symptoms
types of symptoms vary over time
multiple constitutional symptoms
multiple organ system symptoms
individualized responses:
heterogeneous
interdependent
multifactorial
early phase responses
intermediate responses
late phase responses
cumulative
additive
synergistic

SEVERITY OF ILLNESS

severity varies over time
adversely impacts work & major
activities of daily living
complicates management of
concomitant illness



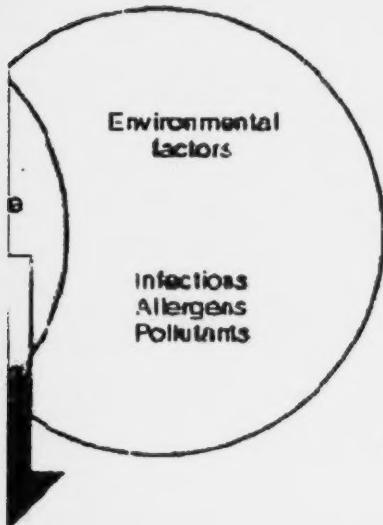
Middleton's Allergy Principles and Practice 6th ed.

1st line Rx - primary
lifestyle changes
allergen & pollutant avoidance
OTC &/or prescription medications
symptomatic care- epi-pen, oxy

2nd line Rx - subspecialty
advanced medications
antigen immunotherapy
hospitalization, surgery

3rd line Rx - regional
treat underlying immune Th1 defect
preservative-free antigen immunotherapy
transfer factor immunomodulation

resents outside the usual spectrum of illness



LIFESTYLE CHANGES
no tobacco, no alcohol
home environmental controls
work environmental controls
rotation - elimination diet
decrease home & work responsibilities

INFECTIONS

In some patients: recurrent viral infections, secondary bacterial infections, mucocutaneous candidiasis but not classic opportunistic infection as in HIV or primary immune deficiencies

Practice 6th Edition Saunders 2008

Primary care
changes
Itant avoidance
ption medications
en. oxygen, steroids etc.

Specialist care
edication use
monotherapy
ion, surgery

Regional center
one Th1-Th2 disorder
tigen immunotherapy
nomodulatory therapy

ALLERGENS
too many different allergies
allergies to too many things
higher % of food allergies
higher % of mold allergies
many have chemical allergies

POLLUTANTS
sensitive to pollutant effects
but are not toxicology patients
or occupational medicine patients

K - TH1 - TH2 DEFECT

TH1 - TH2 IMMUNOBIOLOGY

Figure 2 - Cellular and cytokine precursors of T cells

1. The figure on the left is a simple introduction to the evolution of a basic stem cell into basic immunology cell types. Our focus is on Th1 & Th2 cells which were first identified in 1986.
2. The figure on the right is a simple introduction to the cytokines and other chemical mediators that are precursors to T cell development.

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K - TH1 - TH2 DEFECT

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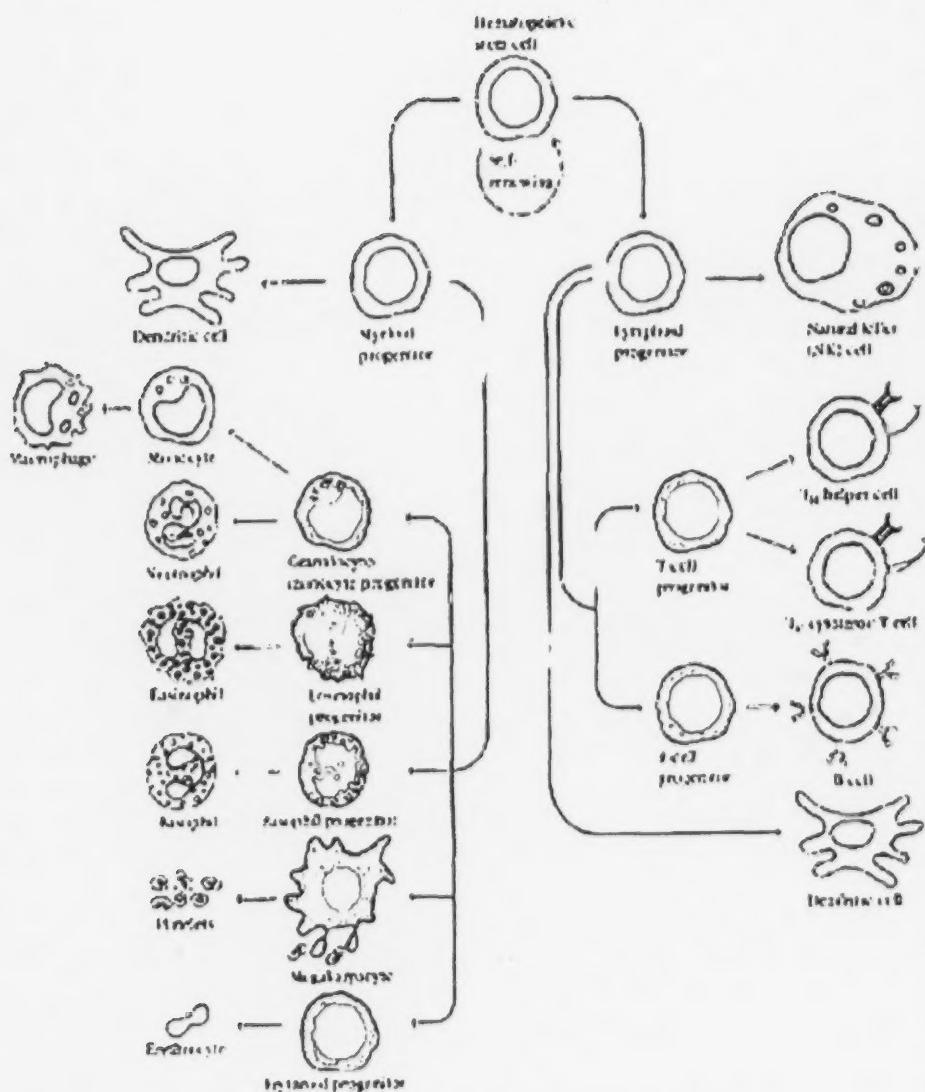
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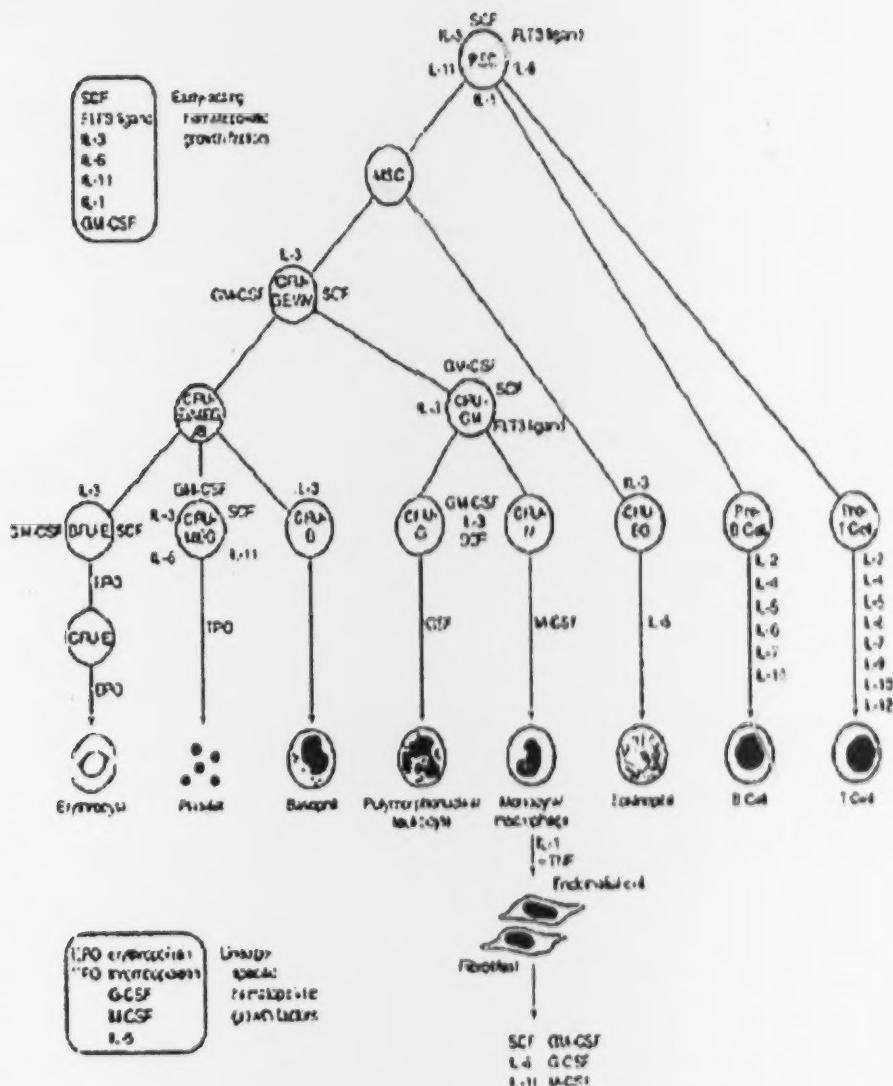
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Cellular and cytokine |



Kuby Immunology; Kindt, T., Osborne B., & Goldsby R. W. H. Freeman; 6th ed; 2006

e precursors of T cells



Kliegman; Nelson Textbook of Pediatrics; 18th ed.; Saunders, 2007 Figure 126-1

K - TH1 - TH2 DEFECT

Figure 3 - Dendritic cells prime naïve T cells to integrate the innate & adaptive immune systems

24. Dendritic cells [hereinafter DC] reside in the tissue where they recognize and ingest antigens. The immune system is programmed to fight microbes, but in genetically susceptible individuals, environmental antigens are perceived as foreign bodies.

The DCs present the antigen engulfed in the peripheral tissue to prime naïve T cells. By capturing and transporting antigens and priming naïve T cells, DCs integrate the responses of the innate and adaptive immune systems.

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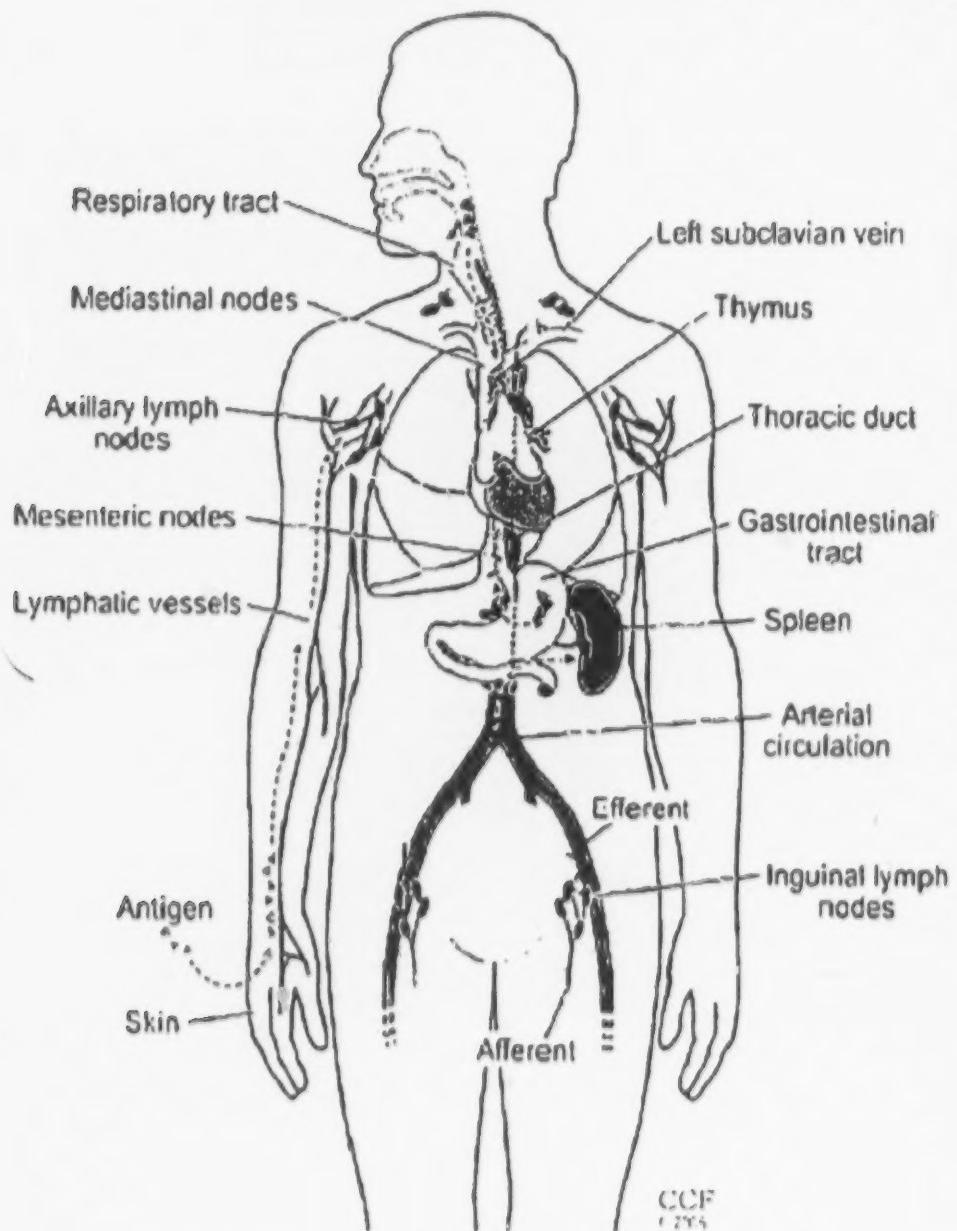
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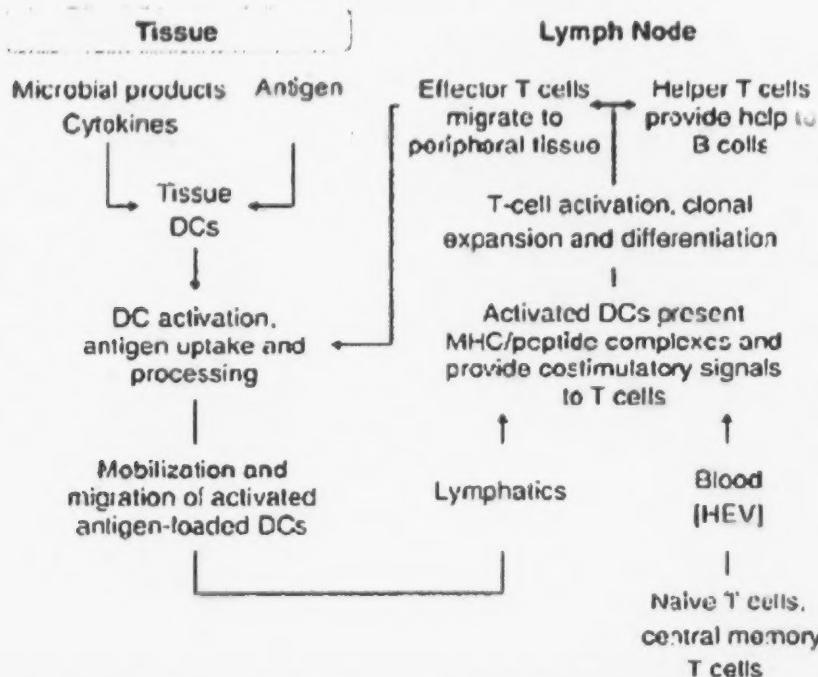
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Dendritic cells prime naïve T cells to integrin



Goldman's Cecil Medicine Saunders 2007 Innate and adaptive immunity

rate the innate & adaptive immune systems



Dendritic cells represent the major cell type linking innate immunity to the adaptive immune system. Their primary function is the presentation of antigens to T cells. They are the only cell type that can activate naive T cells and initiate adaptive immune responses. DCs reside in the tissue, where they recognize and ingest antigens. If they also receive an activating signal such as cytokines, they enter lymph vessels to travel to regional lymph nodes. In parallel, they mature into efficient antigen-presenting cells that express high levels of cell surface major histocompatibility complex (MHC) and costimulatory molecules. In the T-cell zones, DCs present the antigen engulfed in the peripheral tissue to prime naive T cells. By capturing and transporting antigens and priming naive T cells, DCs integrate responses of the innate and adaptive immune systems. [HEV = high endothelial venues]

K - TH1 - TH2 DEFECT

Figure 4 - Innate and adaptive immunity

25. The innate immune system uses early responder hard-wired responses. Our focus is on adaptive T cell immune responses, which are activated by specific antigen presentation.

26. When the innate and adaptive immune systems are working properly, there is ultimately:

- a) a decrease in pro-inflammatory cytokines
- b) an increase in anti-inflammatory molecules
- c) removal of antigen
- d) apoptosis (death) of end-stage immune cells
- e) release of regulatory T cells

27. When there is a genetic predisposition, the immune system is not able to properly regulate cells and mediators and antigen and/or microbes overwhelm the system disease progresses.

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Innate & adaptiv

The innate immune system uses hard-wired responses that are encoded in the host's germ line DNA that recognize many members of a group

Epithelial barriers
Complement
Defensins
Collectins
Toll-like receptors
Phagocytic cells
Natural Killer cells

←————— 12 HOURS —————→

Constitutive Innate Immunity

Commensal bacteria
Ciliated bronchocytes
Antimicrobial molecules
Low pH
Temperature

Barrier Disruption
Physical forces
Chemical forces
Reduced energy
Pathogen



Middleton's Allergy Principles and P

adaptive immunity

The adaptive immune system uses gene segments that rearrange somatically to generate antigen-binding molecules that are highly specifically

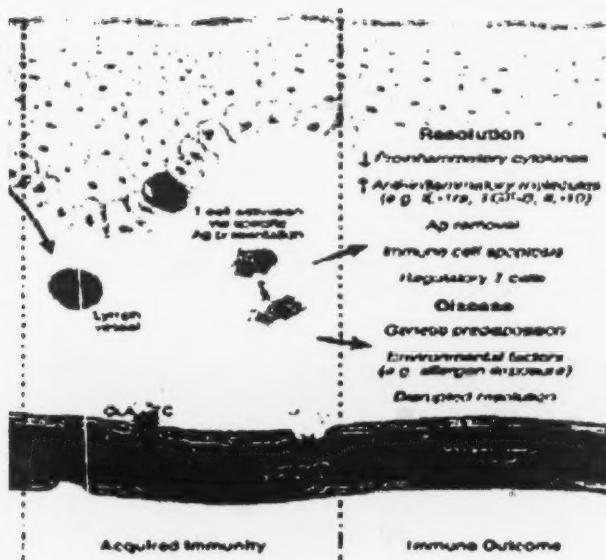
T Cells -----> Effector T cells

Activate Proliferate Mature Memory

B Cells -----> Plasma Cells
Antibodies

Complement ----->

←————— 1 - 7 DAYS —————→



Practica 6th Edition Saunders 2008

K - T H 1 - T H 2 D E F E C T

Figure 5 - Kinetics of Th1 & Th2 cytokine mediated responses

28. There are many types of T cells, cytokines, chemokines and other important mediators that have many feedback loops and continually dynamic interactions. Our focus is on certain interleukins particularly IL4 and IL10 and certain cytokines, especially gamma interferon [hereinafter IFN-g]. We continually discover new pathways, cytokines, chemokines and then reassess and update known molecular pathways. Parallel research is going on in related medical fields, particularly oncology.

Understanding the clinical side is critical to integrating this constantly evolving information.

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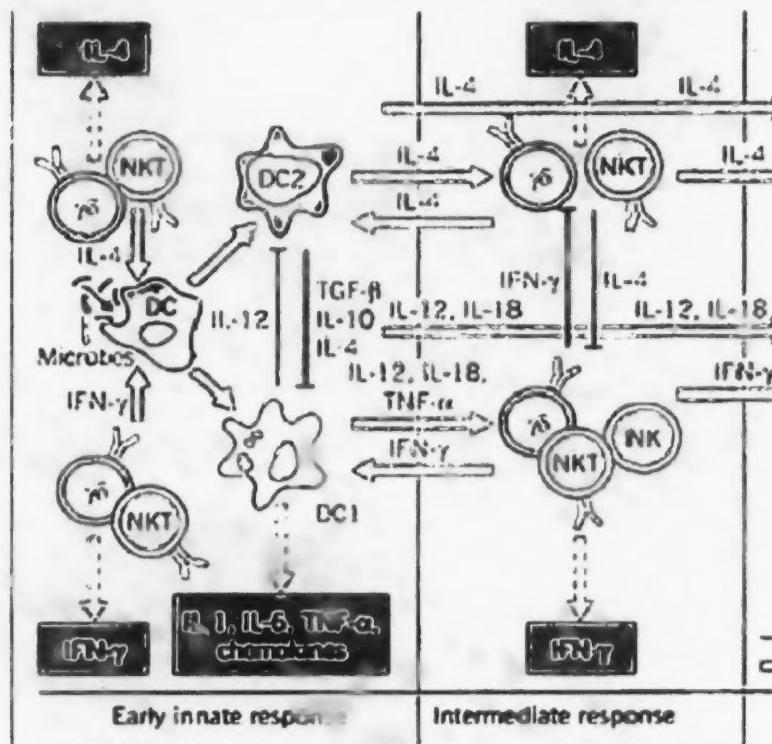
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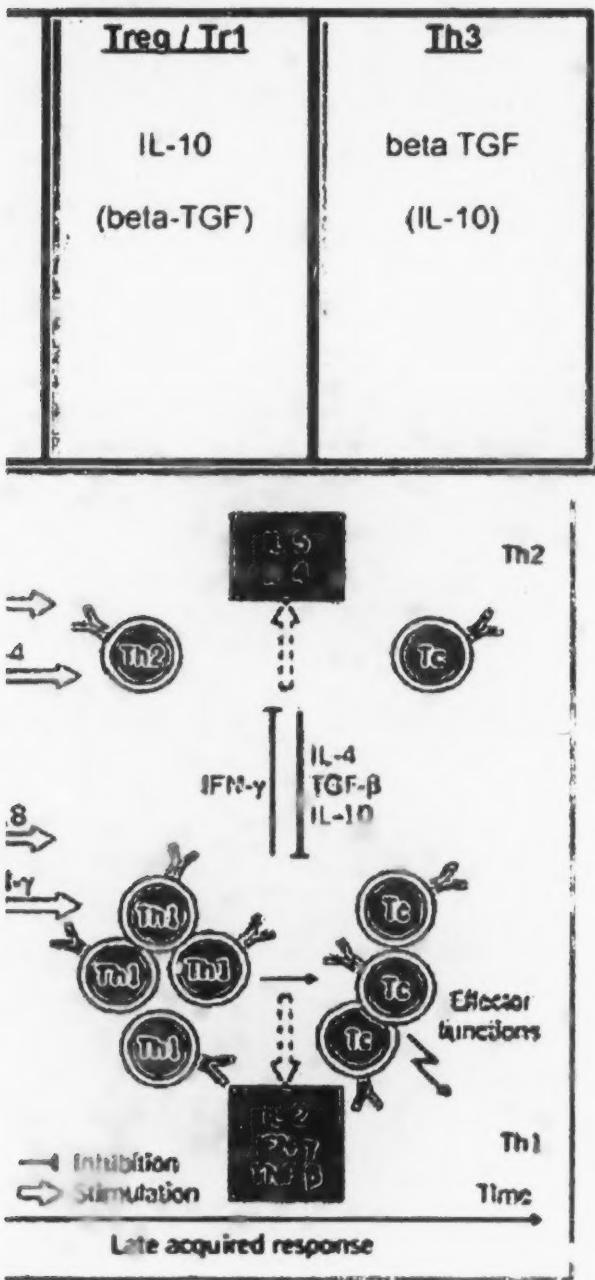
Kinetics of Th1 & Th2 cytokine mediated responses

Th1	Th2	Th17
gamma interferon (IFN- γ)	IL-4	IL-17(IL-17A)
beta-TNF	IL-5	IL-17-F
IL-3 GM-CSF IL-2	IL-9 IL-13 IL-25 IL-31	IL-1 IL-6 alpha-TNF



Cohen & Powderly: Infectious Diseases, 2nd ed

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ed 2008

K - T H 1 - T H 2 D E F E C T

Figure 6 - The cytokine secretion patterns of Th1 cells & Th2 cells are entirely dis- tinct

29. Even though Th1 and Th2 cells are inter-dependent, the cytokine secretion of Th1 and Th2 cells is entirely distinct. The pattern gradually causes specific immune deviation that induces disease, then consolidates it and leads to disease progression and end-stage organ failure.

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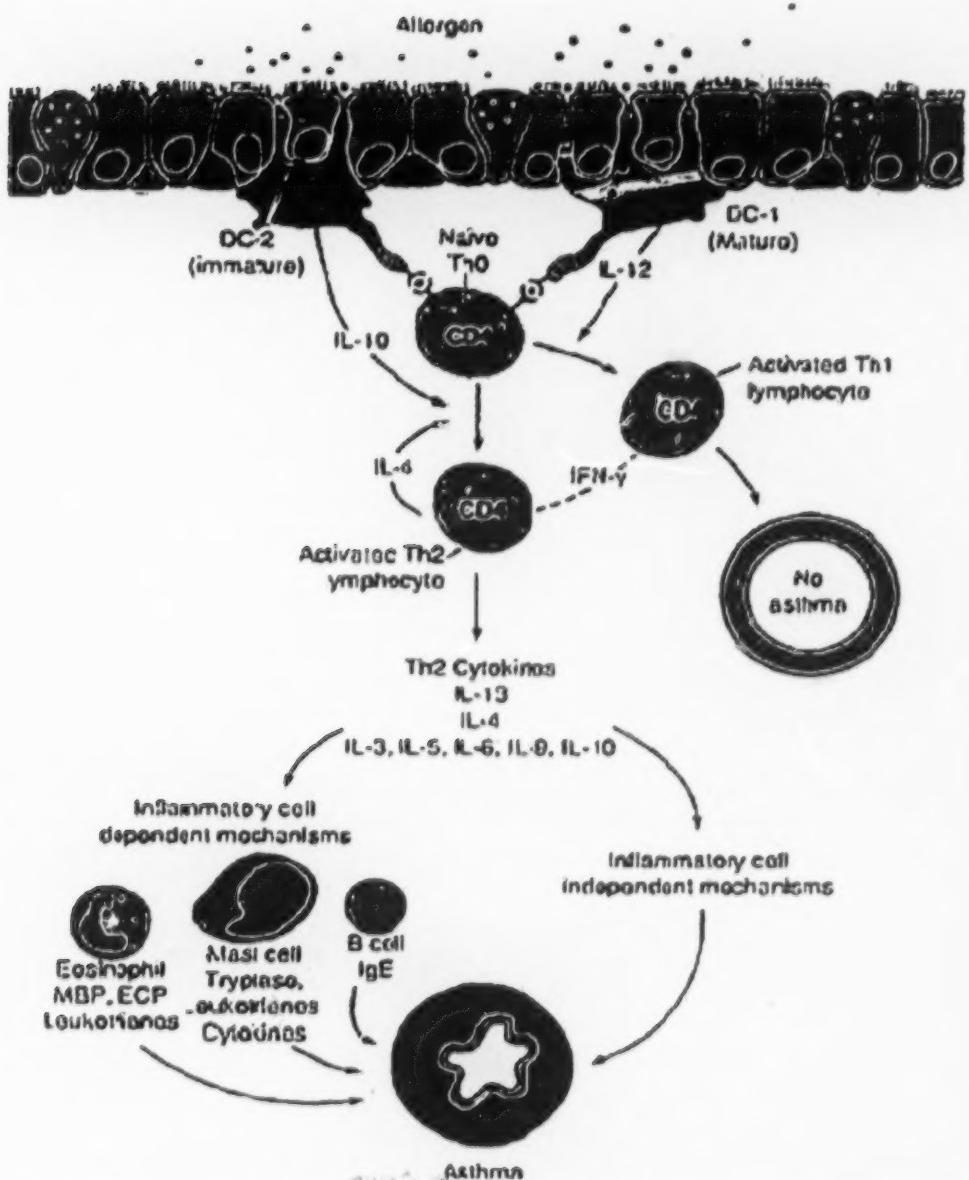
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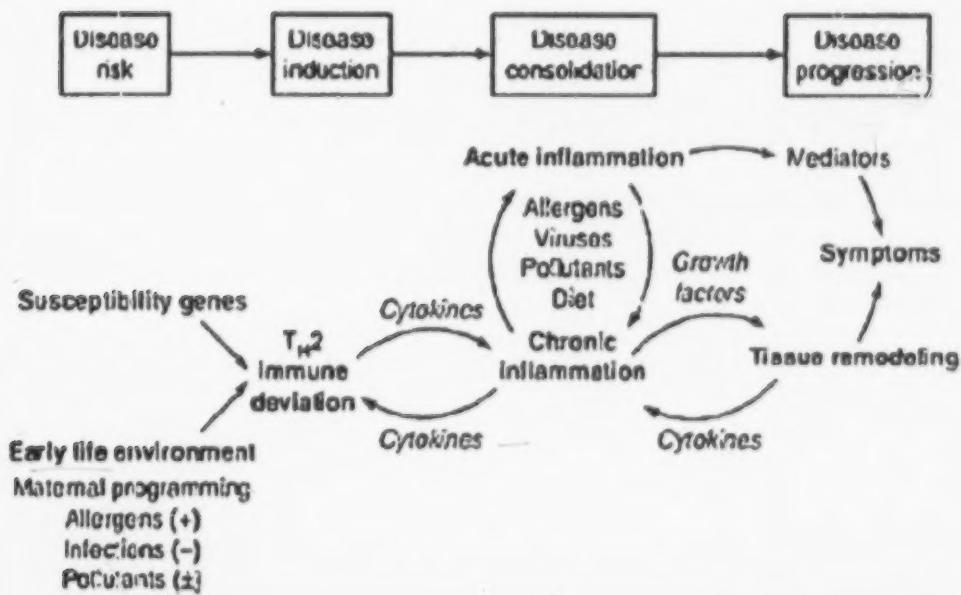
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The cytokine secretion patterns of Th1 and Th2 cells



Mason: Murray & Nadel's Textbook of Respiratory Medicine, 4th Edition Saunders 2005

cells and Th2 cells are entirely distinct



The cytokine secretion patterns of Th1 and Th2 cells are entirely distinct.

Th1

Type 1 cytokines—gamma interferon (IFN- γ), tumor necrosis factor-alpha (TNF α), lymphotoxin, and IL-2—counteract type 2 cytokines and attenuate allergic inflammation.

Transfer factor immunomodulatory therapy modulates the Th1 response.

Th2

The type 2 pattern of Th2 cells (IL-3, IL-4, IL-5, IL-6, IL-9, IL-10, IL-13) is associated with asthma.

The preservative free antigen immunotherapy specifically modulates Th2 response to antigens.

K - TH1 - TH2 DEFECT

Figure 7 - Th1 cytokines [cell mediated immunity] & Th2 cytokines [allergic response]

30. We see how the DCs in the lymphoid tissue impact naïve T cells to differentiate into Th1 and Th2 cells.

31. The Th1 pathway leads to the release of IFN-g and tumor necrosis factor-beta. This is the classic cell mediated / delayed type hypersensitivity pathway.

32. TF is a specific immunomodulatory therapy for abnormal cell mediated immunity identified in 1955 by Sherwood Lawrence, M.D. Chairman of Microbiology and Immunology at New York University Medical Center. He took the buffy coats from healthy human donors and disrupted the cells by:

- a) physically and chemically separating the cells
- b) dialyzing them
- c) using multiple filtrations
- d) using many freeze-thaw cycles.

33. The extract is dialyzable leukocyte extract which contains no cells but many different transfer factors, including cytokines [IFN-g etc] that mediate Th1 pathways.

K - TH1 - TH2 DEFECT

34. The Th2 pathway leads to the release of specific interleukins [IL-4, IL-5, IL-6, IL-10, IL-13] into the system circulation and peripheral tissue leading to anaphylaxis and local allergic responses. The PF antigen immunotherapy regulates the Th2 pathway.

35. When severely impacted patients have a combined Th1 and Th2 immunoregulatory defect, they receive combined immunotherapy: TF and PF antigens.

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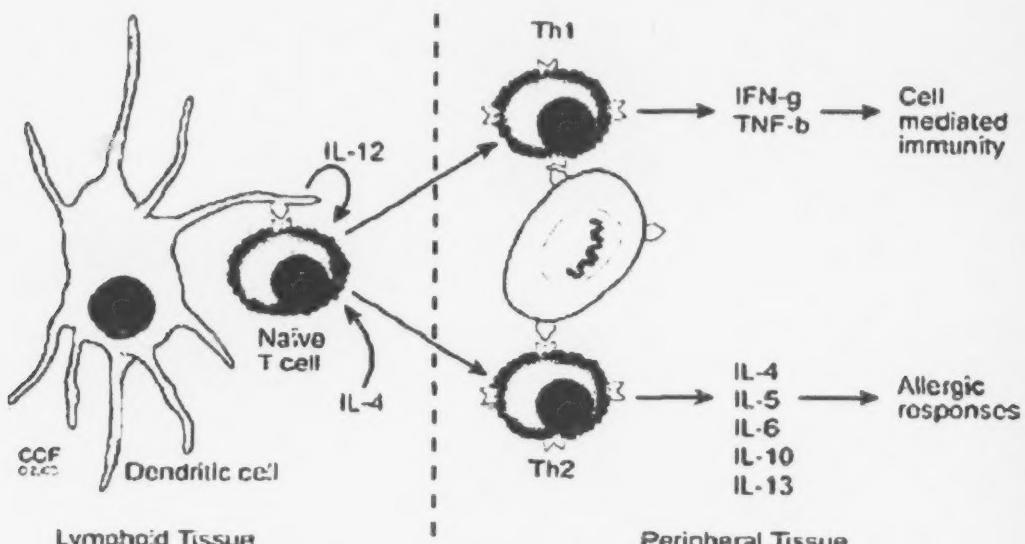
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Th1 cytokines [cell mediated immunity] and Th2 cytokines

<u>Effector & Memory</u>	<u>CD4 cells</u>	<u>CD8+</u>	<u>T regulatory</u>
<p>-Tcm central memory, home to lymph nodes, proliferate well, poor effectors</p> <p>-Tem effector memory home to peripheral tissues poor proliferation good effector function</p>	<p>produce cytokines</p> <ul style="list-style-type: none"> -Th1: gamma-interferon TNF -Th2: IL-4 IL-5 IL-10 IL-13 -Th17 	<p>Cytotoxic T cells</p> <p>functions overlap significantly with T helper cells</p> <p>have cytolytic capacity perform & granzyme mediated secretory cytotoxicity</p>	<p>-distinguished by CD4+, CD25+, GITR, CTLA-4+</p> <ul style="list-style-type: none"> -express Foxp3 -anergic & do not make IL-2 -can suppress conventional T cells -control autoreactive T cells



Wein: Campbell-Walsh Urology, 9th Edition Saunders 2007

es [allergic response]

<u>gamma-delta T cells</u>	NKT
<ul style="list-style-type: none">-produce interferon-gamma, tumor necrosis factor & chemokines-can be cytotoxic-home to epithelial tissues & epidermis-utilize gamma & delta T cell receptor	<ul style="list-style-type: none">-T cells that express natural killer cell markers-iNKT cells (invariant) express limited T cell recognition repertoire-produce gamma-interferon TNF or IL-4/IL-13



Transfer factor
immunomodulatory therapy
(dialyzable leukocyte extract)



Preservative free
antigen immunotherapy

K - TH1 - TH2 DEFECT

Figure 8 - Transfer factor to activate Th1 response & PF antigens to alter Th1 - Th2 balance

36. In our patients, the abnormal cell mediated immunity/delayed type hypersensitivity Th1 pathway on the left responds clinically to TF. The beneficial effects of TF involve many transfer factors, not necessarily any single immune mediator. TF educates the immune system to produce certain cytokines in response to antigenic stimulation.

37. TF can induce large amounts of IL-12 by either activating a large number of Th1 cells or causing increased cytokine production, by selectively activated Th1 cells, which in turn stimulates the production of large amounts of IFN-g. The TF causes important long term benefits in responsive patients.

38. In our patients, the extensive allergies Th2 pathway on the right responds clinically to PF antigens. The antigen immunotherapy restores the balance of immunologic responses and is highly specific for individual antigens. It provides important modification of the natural course of chronic allergic illness. It alters the Th2 / Th1 balance in favor of Th1 responses. IL-10 is an important mediator that can decrease cytokines.

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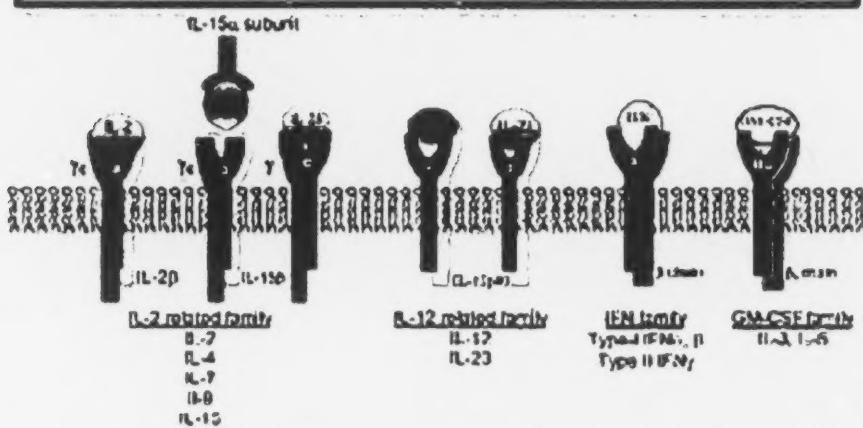
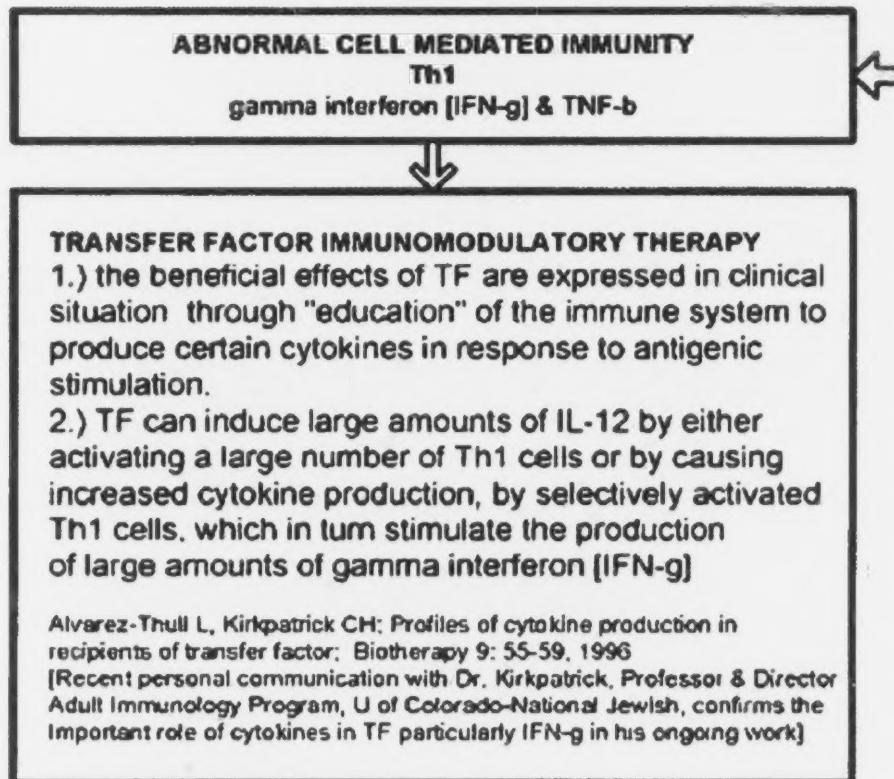
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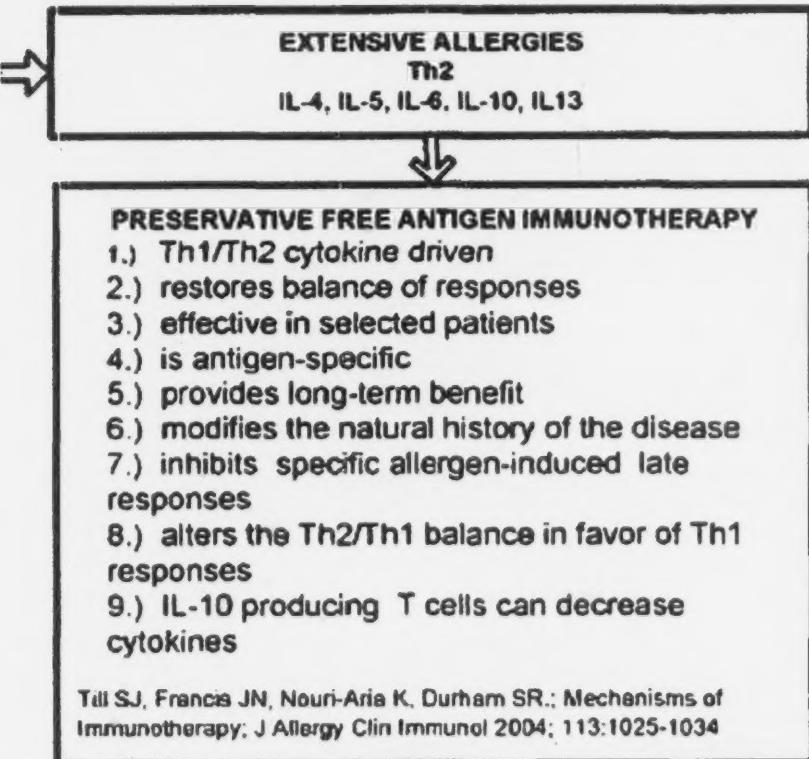
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Transfer factor to activate Th1 response & P

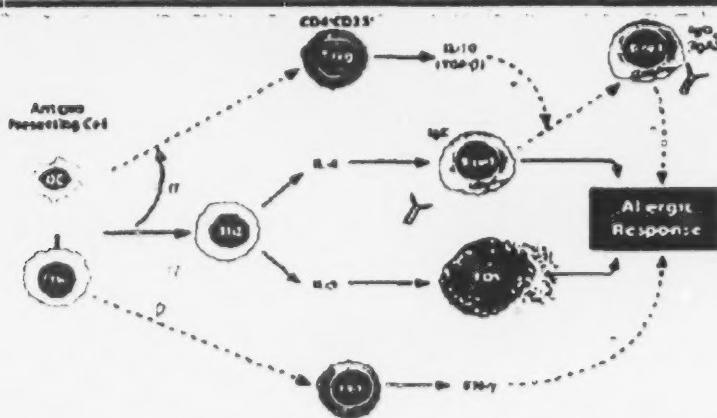


Kim-Schulze S, et al. Cytokine therapy for cancer. Surg Oncol Clin N Am. 2007

PF antigens to alter Th1 – Th2 balance



Til SJ, Francis JN, Nouri-Aria K, Durham SR.: Mechanisms of Immunotherapy. *J Allergy Clin Immunol* 2004; 113:1025-1034



IFN- γ , gamma interferon; T reg, regulatory cell; DC, dendritic cell; EOS, eosinophil.

K - TH1 - TH2 DEFECT

FOOD

Figure 9 - Th1 cytokines, Th2 cytokines & other food allergy immune mediators

- /
39. Local allergist - immunologists and otolaryngologic allergists are very skilled at treating grass, tree & weed pollen, dust, mite, animal allergy with pharmaceuticals and preserved antigen immunotherapy. But most rely on avoidance and rotation of allergenic foods as the primary therapeutic strategy for the food allergic patient. This works fine except for those who are severely food allergic, particularly to common foods.
40. Here we see that combined Th1 - Th2 immunoregulatory defects play an important role in food allergic patients, as well as the dynamically complex immunologic and gastrointestinal milieu.
41. Minority-opinion allergists have specialized CME training in food antigen immunotherapy, which is extremely effective in properly selected patients. But we cannot test every important food allergy. Food allergies notoriously change with dietary and environmental change. This is where TF is an important adjunct to the PF antigens, stabilizing the underlying Th1-Th2 immunoregulatory defect, and allows the immune system to heal.

K - TH1 - TH2 DEFECT

42. Furthermore, these more severe food allergy patients, almost invariably are extremely mold sensitive, and many are chemically sensitive. They need basic immunologic support in addition to specific Th2 therapy for the food allergies.

43. Many of these patients have ravaged guts. One of my sons with this Th1-Th2 defect, was hospitalized as an exclusively breast-fed infant. He was intolerant to formula and foods with extreme projectile vomiting, diarrhea, eczema and so forth. The UCSF Medical Center GI team transferred after an unsuccessful hospitalization to my mentor, Douglas S. Sandberg, M.D., Professor of Pediatrics, Chief of Gastroenterology, Allergy and Nutrition at the U of Miami Medical Center for specialized care. Dr. Sandberg had to stop all feeding to allow his gut to heal, fed him with total parenteral nutrition for a full month, and started the PF antigens and TF. My son received the gift of another 16 years of life on long term PF antigens and TF.

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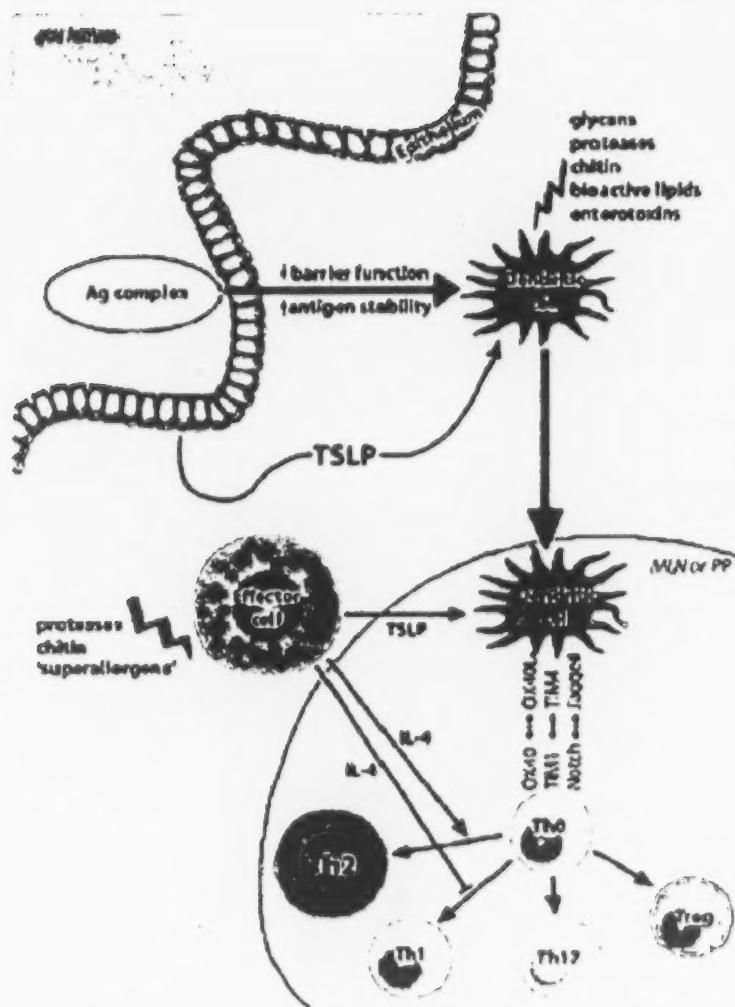
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Th1 cytokines, Th2 cytokines

*many mediators



Benn M. et al: Th2 adjuvants: Implications for food allergy:
Journal of Allergy and Clinical Immunology, Vol 121, No 6, 2008

lines & other food allergy immune mediators

are released in more than one type of reaction

Ig E BASED HYPERSENSITIVITY

Vasoactive mediators

histamine, leukotrienes (C D & E), platelet aggregating factor (PAF), serotonin, prostaglandins

Chemotactic mediators

eosinophilic chemotactic factor, neutrophil chemotactic factor, leukotriene B, prostaglandin D2

Enzymes

tryptase, aryl sulfatase, chymase, beta-glucuronidase, beta-hexaminidase, heparin, kininogenase

Cytokines

tumor necrosis factor-alpha, IL5, IL8, transforming growth factor-beta

IMMUNE COMPLEX REACTIONS

Platelets

serotonin

Neutrophils

lysosomal enzymes, PAF, cationic protein

Macrophages

tumor necrosis factor-alpha, IL1

Mast cells

C-reactive protein, histamine, leukotrienes, prostaglandins

CELL MEDIATED IMMUNITY

Tcells

(Th1) IL2, gamma-interferon, lymphotoxin

Macrophages

macrophage inhibitory factor, tumor necrosis-alpha, IL1

Brostoff, J. & Challacombe, S.J., Food Allergy & Intolerance, Saunders, 2002, Table 21.1

K - T H 1 - T H 2 D E F E C T

Figure 10 -Th1 and Th2 cytokine imbalance in food allergy patients

44. This elegant study published in Allergy, measures the Th1 - Th2 balance in patients with documented food allergies. The Th1 cytokine, IFN-g, is significantly suppressed. The Th2 cytokine, IL-4, was increased when compared to health patients.

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K - TH1 - TH2 DEFECT

II

Th1 and Th2 cytokine imbalance

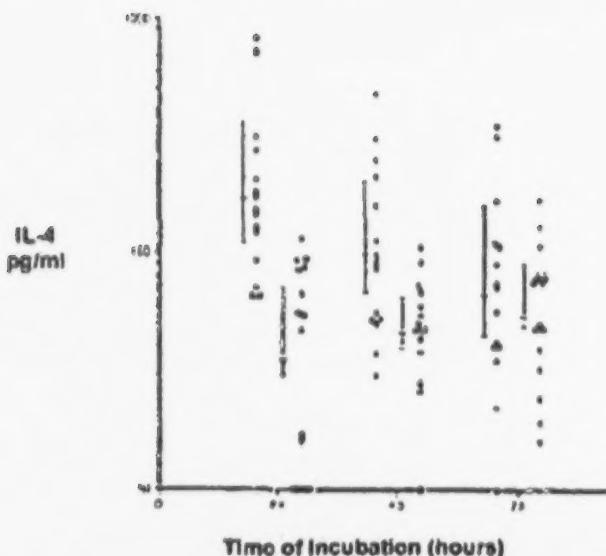


Fig. 1 Production of IL-4 after 24-, 48-, & 72-hour incubation in PHA- plus PMA- stimulated cultures from patients with food allergy

The aim of this study was to investigate whether patients with food allergy have an altered pattern of cytokine production. Diagnostic procedures included serum IgEs, and positive double-blind, placebo-controlled, food challenges in 15 age- and sex-matched healthy subjects. Peripheral blood monocytes were stimulated for 24, 48, and 72 h in the presence of phytohemagglutinin plus phorbol myristate acetate.

After mitogen stimulation, culture supernatants from patients with food allergy showed increased IL-4 when compared with healthy controls. Secretion of IL-4 was maximal at 72 h. There was no correlation between cytokine production and food-specific IgE. It is demonstrated that an imbalance of IL-4 and IFN-gamma production may play a role in the pathogenesis of allergic diseases, but other mechanisms are probably also involved.

Andre F. et al.: Interleukin-4 and interferon-gamma production by peripheral blood monocytes from patients with food allergy

ce in food allergy patients

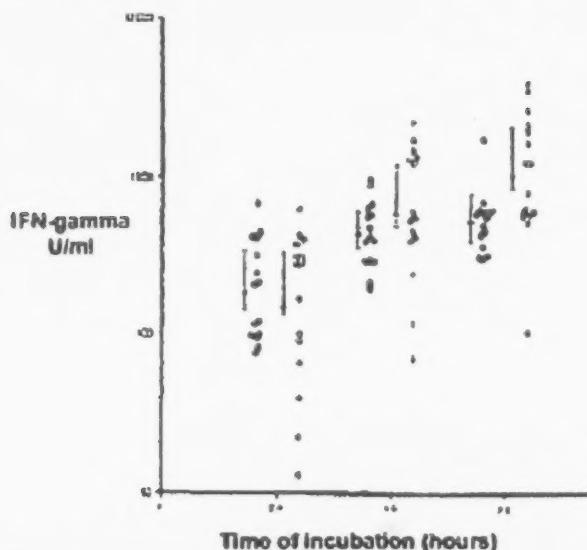


Fig. 2 Production of IFN-gamma after 24-, 48-, & 72-hour incubation in PHA- plus PMA- stimulated cultures from patients with food allergy

food allergy had a cytokine imbalance of interleukin (IL)-4 and IL-13. Subsequent procedures including skin prick tests, determination of food-specific IgE antibodies, and oral food challenges identified 15 adult patients. They were compared with 15 healthy volunteers. Blood mononuclear cells (PBMC) were incubated for 24, 48, and 72 h with PHA and PMA.

Patients with food allergy contained significantly less IFN-gamma but more IL-4. The peak of IL-4 was maximal at 24 h and IFN-gamma secretion was maximal at 72 h. IL-13 secretion in vitro and serum IgE level were increased in patients with food allergy. These findings indicate that cytokine imbalance is present in food allergy, as documented in other diseases.

Food mononuclear cells from food-allergic patients. Allergy. May;51(5):350-5 1996

K - TH1 - TH2 DEFECT

Figure 11 - Cross-reactivity between allergens

45. Clinical observations in allergy-immunology traditionally precede our understanding of the basic science, frequently by decades. When I was doing pediatric surgery in 1975, the pediatric surgery chief resident brought her own sets of sterile surgical gloves and I brought my surgical mask that I washed myself in a mild detergent. She was sensitive to latex. I was sensitive to the hospital detergent and could not be scratching my face throughout the operations. But latex allergy was not defined in the medical literature until many years later. And not everyone who reacts to latex surgical gloves is allergic to latex. The chemical processing of "natural" rubber to powdered latex surgical gloves introduces more than one potential allergenic trigger.

46. It is well accepted in the allergy community that specific foods frequently cause allergy in latex sensitive patients but we have not defined the basic science as to why.

47. There is similar unexplained cross reactivity between certain pollen and fruit and vegetables.

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Supreme Court, U.S.
FILED

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OFFICE OF THE CLERK

In the
Supreme Court of the United States

Paul Messer & Dorothy Calabrese, M.D.
Petitioners,
v.
U.S. Department of Health and Human Services
Respondent.

Petition for a Writ of Certiorari
to the U.S. Court of Appeals
for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

Volume 2 of 2

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Laguna Hills, CA 92653
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Fax: 949-454-2033
dvc9@columbia.edu
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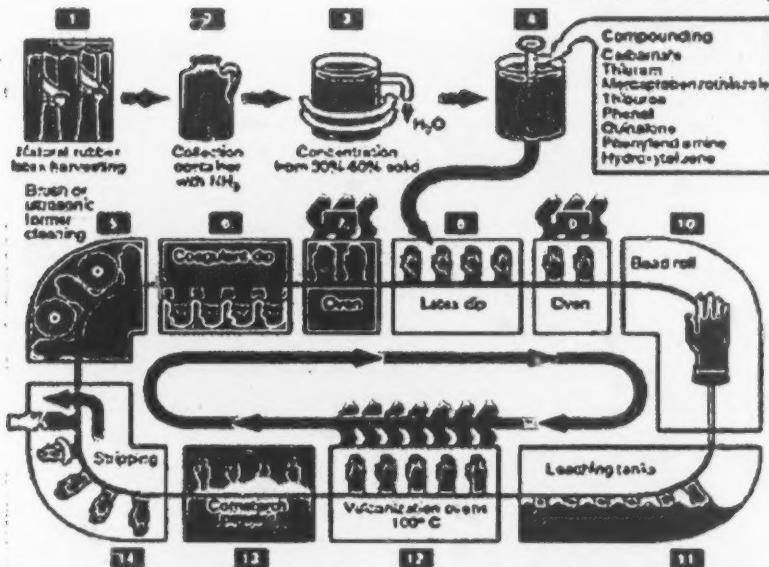
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Cross-reactivity between a



Example of a natural rubber glove manufacturing process

- 1) Natural latex-containing protein harvested from *Hevea brasiliensis* rubber trees.
- 2) Autocoagulation of natural latex is prevented by addition of ammonia (NH₃).
- 3) Natural latex is centrifuged and concentrated from 30% to 60% solids. Removal of the serum phase reduces the concentration of water-soluble proteins.
- 4) Processing and attributes depend on the addition of many chemicals to the natural latex (compounding). Significant type IV allergens include accelerators and antioxidants.
- 5) Porcelain formers attached to a continuous chain are cleaned to remove debris from the previous cycle.
- 6) Formers are dipped in an emulsion to apply cornstarch as a releasing agent and a compound that coagulates liquid natural latex on contact.
- 7) Releasing agent and coagulant are oven-dried.
- 8) Formers dip into natural latex and a uniform film is deposited.
- 9) The coagulant and heat convert the natural latex from liquid to solid.
- 10) Rotating brushes contact the rotating formers and a cuff is rolled onto the glove.
- 11) Formers pass through warm water baths to remove water-soluble proteins and excess additives.
- 12) Cross-linking of the polyisoprene polymers is catalyzed by heat with an accelerator.
- 13) Cornstarch is applied as a slurry to the outer surface of the natural rubber latex glove as a detackifying agent. Residual rubber proteins may elute from the gloves at this point and bind to the cornstarch particles.
- 14) The gloves are stripped from the porcelain formers.

Middleton's Allergy Principles and Practice 6th Edition Saunders 2008

allergens

Foods cross-reactivity with natural rubber latex

These foods most frequently cause clinical allergy in latex-allergic persons:

avocado, kiwi fruit, banana, potato, tomato, chestnut, papaya

By skin testing or immunoassay for specific IgE, latex-allergic persons may be cross-sensitized to these foods, but clinical allergy is less common:

passion fruit, fig, melon, mango, pineapple, peach, pear, celery, cantaloupe, apple, cherry, wheat, turnip, spinach

Patterns of pollen-fruit & vegetable cross-reactivity

Birch

apple, peach, plum, nectarine, cherry, almond, hazelnut, carrot, celery, hazelnut

Ragweed

melons (watermelon, cantaloupe, and honeydew), Banana, tomato

Grasses

tomato, melons, kiwi

Mugwort (weed)

carrot, celery, spices

Nowak-Wegrzyn A - Adverse reactions to foods
Medical Clinics of North America - 01-Jan 2006; 90(1)

K - TH1 - TH2 DEFECT

Figure 12 - Importance of single case reports

45. Care is medically necessary when it makes scientific sense and is therapeutically effective, even if you are a single case report. We see this most commonly with off-label use of pharmaceuticals. Lewis Goodfellow, an infant born weighing only 1 pound, 8 ounces, had a heart defect and collapsed lung and was clinging to life on 100% oxygen with maximal ventilator settings. Viagra helped open up tiny blood vessels in Lewis' lungs so blood could pump away from the lungs and toward the rest of the body -- similar to the way it works for impotent men. This is how clinical medicine evolves. We can be certain the Viagra reimbursement was not excluded because it failed to meet some regulator's definition of medical necessity.

46. The 1997, single case report from the New England Journal of Medicine was the first case report of transfer of peanut allergy associated with liver transplantation. Subsequent to this there has been substantial identification of the strong role the liver plays in allergy, a major departure from our understanding of the role of the liver in allergy and immunology up until that time.

47. Many of our patients qualify as single case reports, because they have multiple medical ill

K - TH1 - TH2 DEFECT

nesses that create unique clinical presentations. So you start with the basics, such as reevaluating their thyroid. Then as appropriate, you treat the combined Th1-Th2 immunoregulatory defect. It has been my consistent experience that after the first year of PF antigens and TF, the complex catastrophic patients start to look like other regular patients in their internists or pediatricians' practices. Their attending physician is relieved because they then clearly see how to manage any remaining or future medical problems.

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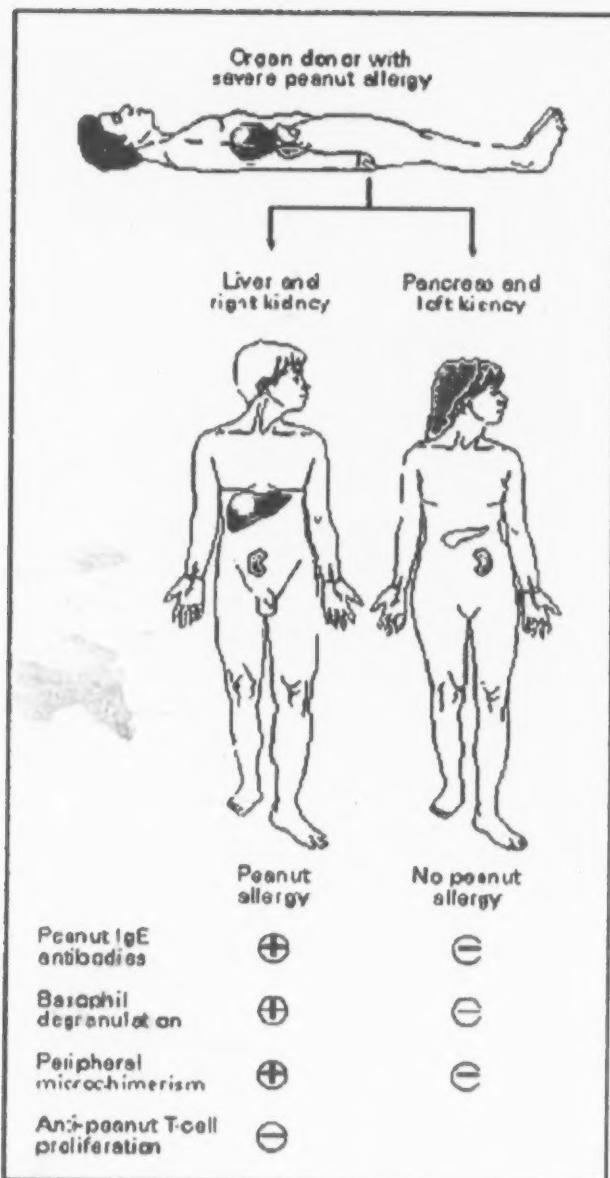
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Importance of sing



of single case reports

A 22 yo man ingested satay sauce, which contains peanuts, and went into cardiorespiratory arrest with cerebral anoxia, coma and brain death. The donor's liver and right kidney were transplanted into a 35 yo man. The left kidney and pancreas were transplanted into a 27 yo woman. Both recipients were negative for peanut allergy. Neither was told the cause of death of the donor was peanut allergy. They were both treated with immunosuppressive drugs.

Three months post-transplant the liver-kidney recipient reported a skin rash and laryngeal dyspnea after ingesting peanuts. Peanut IgE specific antibodies were negative pre-TX and now were positive only in the liver-kidney recipient. Basophil degranulation test was positive. There was a substantial proliferative response to purified protein derivative, but no peanut-specific proliferation.

The pancreas-kidney recipient had no peanut allergy clinically on oral challenge and her tests were negative for peanut allergy.

Pluripotent hematopoietic stem cells and dendritic cells are known to be normally resident in the liver. Such cells may have immunomodulatory effects that result in donor-specific immune tolerance. Migration of donor-derived cells into the recipient's skin is suggested by the microchimerism in the skin, and the skin was one site of the allergic reaction.

Legendre C et al; Transfer of Symptomatic Peanut Allergy to the Recipient of a Combined Liver-and-Kidney Transplant; New England Journal of Medicine Vol 337, No 12, 823

K - TH1 - TH2 DEFECT

MOLD

46. Our annual UCLA - UCI Mold symposium features Dr. Harriet Burge. She is widely considered to be the leading expert in Indoor Air Quality, and pioneered mold investigations in indoor environments. She has served as a member of three National Academy of Sciences committees for indoor air quality, including as vice-chair of the Committee on the Health Effects of Indoor Allergens, and is currently chairing the National Academy of Sciences Committee on Damp Buildings and Health. Dr. Burge serves on the Board of Directors of the New England Chapter of the Asthma and Allergy Foundation of America, is a Fellow of the American Academy of Allergy and Immunology and the American College of Allergy and Immunology and was a member of the ASHRAE Standard 62 (Ventilation for Indoor Air Quality) Committee. She has published more than 50 peer-reviewed papers on bioaerosols, fungi and respiratory health, and is the author of several books relating to allergies and air quality.

47. Dr. Burge states that the only really effective mold antigens for immunotherapy are non-preserved fresh frozen in individual patient aliquots, but that no doctors want to invest the time and effort. However, this is exactly how I have prepared all my antigens for the past 27 years. So the antigen immunotherapy for mold is much more effective than the local allergist

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and adequately, frequently spectacularly, addresses the Th2 side of mold allergy.

48. Fungal diseases include hypersensitivity, the most prevalent disease caused by air-borne fungi, including species of Alternaria, Aspergillus, Cladosporium and Penicillium, and a large number of other illnesses, including allergic chronic sinusitis, hypersensitivity pneumonitis and atopic eczema/dermatitis syndrome: AEDS (formerly atopic dermatitis).

49. Sensitization to molds is frequent in our patients with sinusitis, asthma, and AEDS. There is evidence that fungal sensitization also contributes to autoreactivity against self-antigens due to shared epitopes with homologous fungal allergens adversely impacting their pro-inflammatory and anti-inflammatory balance.

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K - TH1 - TH2 DEFECT

Figure 13 - Th1 and Th2 cytokines impact proinflammatory and anti-inflammatory mediator balance

50. TF is particularly effective because it is derived from 33 pooled healthy human volunteer donors and has >120 moieties that can be selectively absorbed by the recipient and there is extensive plasticity in the T-cell response to fungi. The heterogeneity of the CD4+ and CD8+ T cell repertoire may account for the multiplicity and redundancy of effector mechanisms through which T lymphocytes participate direct antifungal activity, apoptosis and complex effector functions resulting from the dynamic interactions between T cells bearing selected members of the V β families of the T cell receptor. The functional plasticity is such to uncover vaccine potential in conditions of immunodeficiency.

The flexible program of the T lymphocytes also implicates the production of a number of mediators, including cytokines. Due to their action on circulating leukocytes, the cytokines produced by fungus-specific T cells are instrumental in mobilizing and activating antifungal effectors, thus providing prompt and effective control of infectivity once the fungus has established itself in tissues or spread to internal organs.

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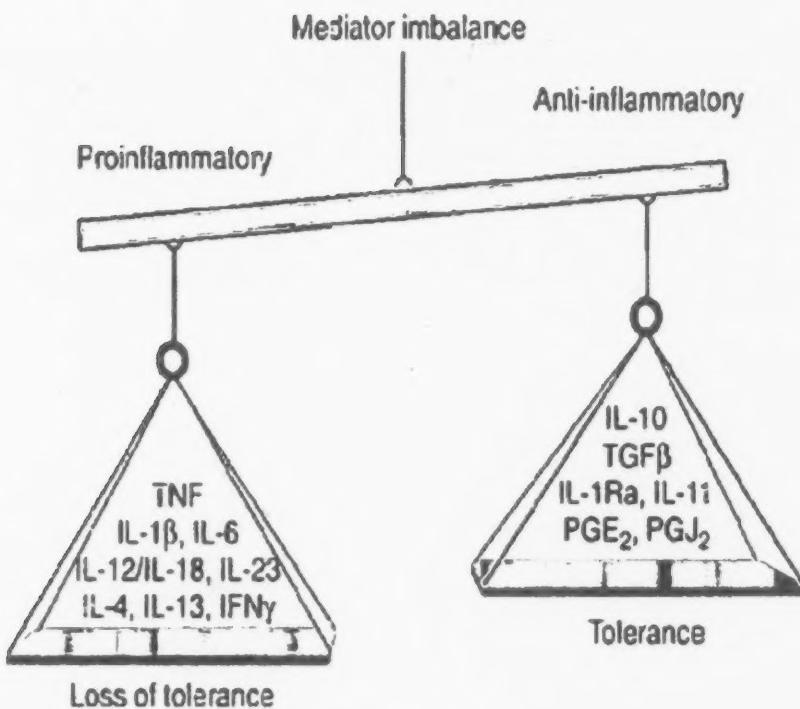
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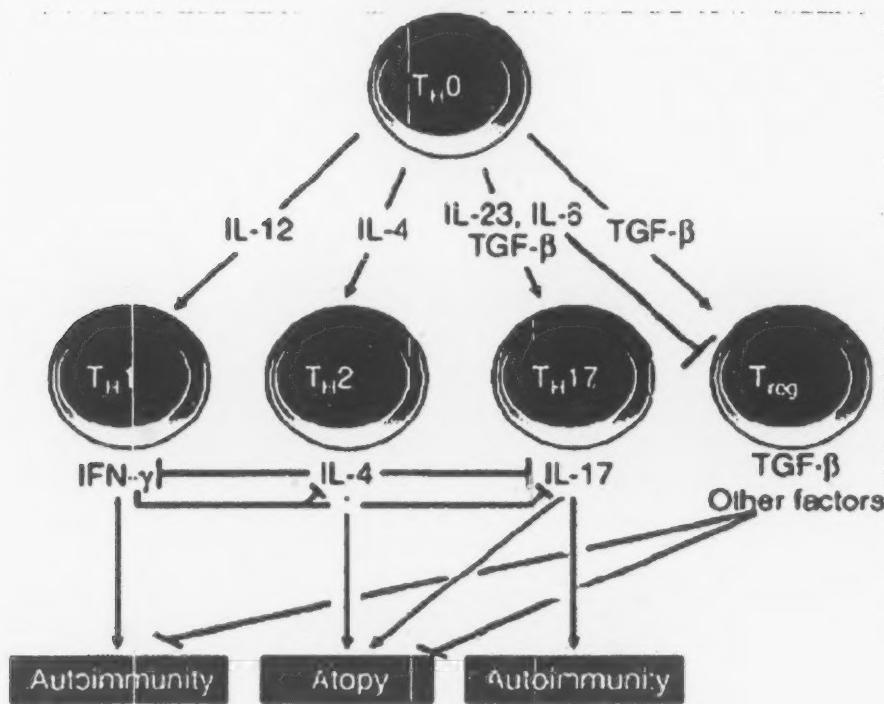
Th1 and Th2 cytokines Impact proinflammation



Feldman: Selsenger & Fordtran's Gastrointestinal and Liver Disease, 8th ed. Saunders, 2006

The relative balance of proinflammatory and protective cytokine (tolerance) versus protection (tolerance), atopy and autoimmunity, and/or Th2 immunomodulatory therapy (preservative-free anti-expression of proinflammatory and anti-inflammatory mediator bal

Inflammatory and anti-inflammatory mediator balance



R. L. Rabin; The nexus between atopic disease and autoimmunity;
Clinical & Experimental Immunology; Volume 153 Issue 1, pp 19 - 30

lines and inflammatory mediators determines tissue injury (loss of integrity). Treatment with Th1 immunomodulatory therapy (transfer factor) or antigens helps define and repair the relationship between the balance

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**Figure 14 - Th1 & Th2 balance affects
fungal clearance,
fungal immunity and mold allergy**

51. On the left, we see recognition of *Candida albicans* by dendritic cells. *Candida* is a normal commensal organism in healthy individuals.

52. Dendritic cells sample fungi at the site of colonization/infection, transport them to the draining lymph nodes and activate disparate Th/Tregs cells. This culminates in cytokine-dependent Th cell activation, including an immunogenic, MyD88-dependent program culminating in the production of IL-12 - and eventually leading to protective Th1 cells - or, in cooperation with dectin-1, of IL-23, and possibly other inflammatory cytokines, which activate pathogenic Th17 cells - promoting inflammation and dampening Th1 responses. By inducing IL-10, the tolerogenic, TRIF-dependent pathway contributes to regulatory T cell induction - balancing innate and adaptive inflammatory immunity. The production of IL-4 leads to activation of Th2 responses opposing antifungal function in effector cells and promoting allergic manifestations.

53. On the right, we see the 2008 update of the different Th cell subsets, their transcription

K - TH1 - TH2 DEFECT

factors and possible effector functions from Medical Mycology. This finely orchestrated balance between activating and inhibitory signals is fundamental for the ability of the immune system to effectively attack and eliminate pathogenic fungi and/or coexist with commensals without reacting against self-antigens. Derangements underlie allergic responses to molds, infections and autoimmune inflammatory diseases. For our patients, the Th1 - Th2 balance itself is the target of PF antigen immunotherapy and TF.

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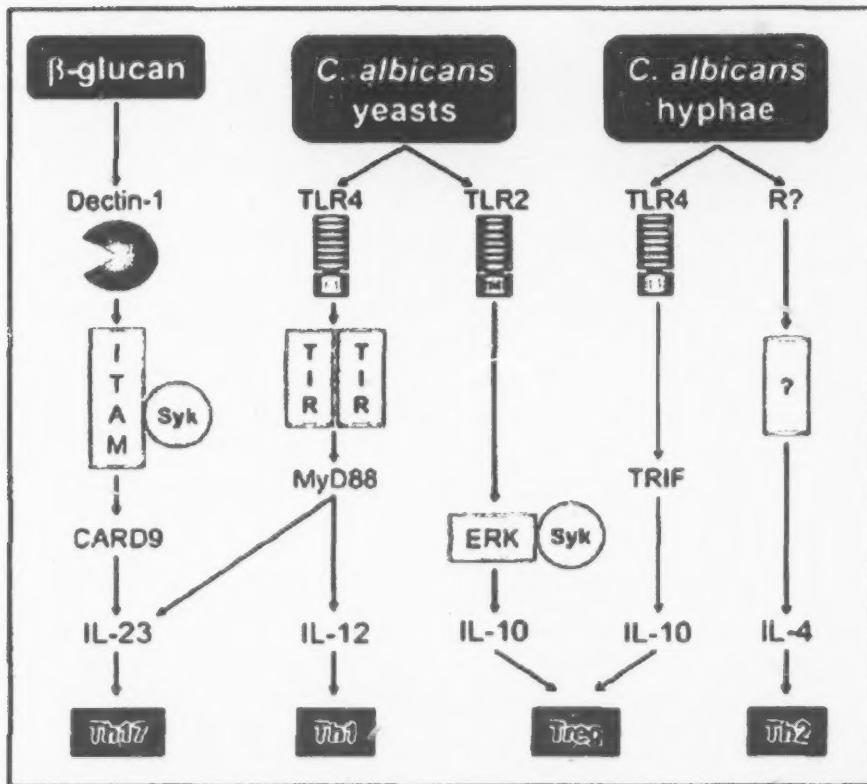
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Th1 & Th2 balance affects fungal clearance



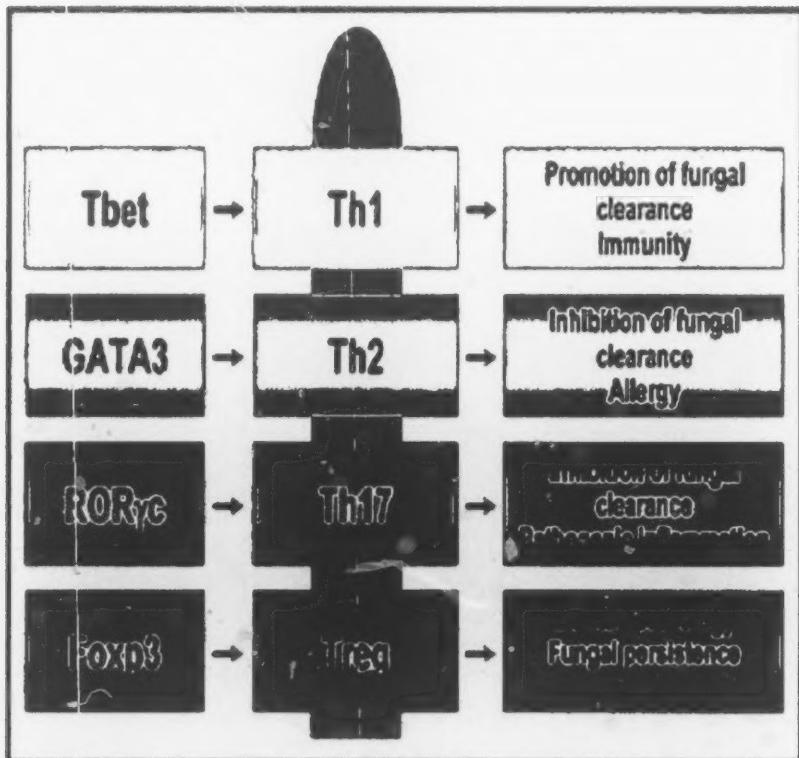
Th1 and Th2 responses

Th1 responses (cell mediated immunity) have been considered the cornerstone of antifungal defense. Th1 responses are cell-dependent pathways that have come of age. Th1 promotes fungal clearance via cytokines such as TNF- α , IFN- γ , and GM-CSF, and transfer factor immunomodulatory therapy.

Th2 responses (allergic responses) inhibit fungal clearance and promote fungal persistence. Th2 responses are antibody-dependent pathways that include IgE and IgG4, and free antigen immunotherapy pathway.

Romani L.; Cell mediated immunity to fungi: a review. *Eur Respir J* 2002; 20: 103-112.

Barance, fungal immunity and mold allergy



I Th2 balance

red central to protection against fungi. Now other cytokines and T
ngal clearance and immunity. This is the pathway activated by

and promote allergic response to molds. This is the preservative-

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CHEMICAL

Figure 15 - Th1 & Th2 cytokine response in allergic hypersensitivity to diesel exhaust particulate

54. Since I first started practicing allergy-immunology in 1980 at Kaiser Permanente Medical Center, majority-opinion allergist-immunologists debunked allergic response associated with chemicals such as diesel exhaust particulate(DEP). But clinically, DEP could trigger the exact same responses as other immunologically medicated processes in our patients. Furthermore, their debunking of allergic hypersensitivity to chemicals was inconsistent with the well-known and accepted phenomenon of the fragrance, not the pollen, of blooming jasmine causing severe asthma.

55. We now have a body of consistent peer-reviewed literature showing the role of interdependent role Th1 and Th2 cytokines in our patients sensitive to multiple chemicals. (Citation 247-301)

56. This 2005 data from the AAAI's Journal of Allergy and Clinical Immunology meticulously documents the immunobiology of DEP on multiple cell types. It compares DEP effects on healthy individuals where they have documented more manageable immune changes.

K - TH1 - TH2 DEFECT

Our patients with the combined Th1 - Th2 immunoregulatory defect, are much more adversely impacted and have progressive difficulty mounting an appropriate immunologic recovery.

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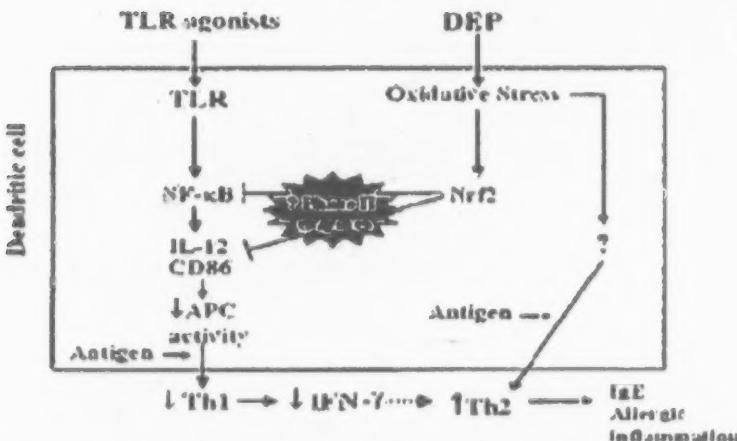
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Th1 & Th2 cytokine response in allergic hypersensitivity



DIRECT EFFECTS OF DEPS ON MULTIPLE CELL TYPES

A. Bronchial and nasal epithelial and endothelial cells

Increase expression of chemokines and cytokines

(IL-8, cathepsin G, RANTES, GM-CSF, and IL-6)

Increase expression of histamine 1 receptor

Upregulate expression of adhesion molecules (ICAM-1)

Increase phase 2 enzyme expression

B. Eosinophils

Enhance adhesion to nasal epithelial cells

Induce eosinophil degranulation

C. Mast cells

Enhance IgE-mediated histamine release

Enhance cytokine production (IL-4, IL-6)

D. Basophils

Induce histamine release in the absence of IgE

Enhance cytokine production (IL-4)

E. Peripheral blood mononuclear cells

Induce chemokine production (IL-8, RANTES)

Synergize with allergen to increases in IL-8, RANTES, and TNF- α

F. B cells

Enhance IgE production after IL-4 and anti-CD40 stimulation

G. Monocytes-macrophages

Modulate cytokine production (e.g., inhibits IL-12p40 production)

Inhibit prostaglandin E2 release

Increase phase 2 enzyme expression

c hypersensitivity to diesel exhaust particulate

CLINICAL EFFECTS OF DIESEL EXHAUST IN HUMAN CONTROLLED EXPOSURE STUDIES

A. Diesel exhaust effects on healthy subjects

- Increased number of inflammatory cells
 - (neutrophils, B cells, T cells, mast cells) in the airways
- Increased circulating neutrophils and platelets
- Increased histamine levels
- Increased cytokines (IL-8) and CXC chemokines (IL-8 & GrO-a)
- Increased expression of adhesion molecules ICAM-1 & CAM-1
- Decreased macrophage function
- Increased airway resistance

B. Diesel exhaust effects on subjects with mild asthma

- Increased hyperresponsiveness to methacholine
- Increased airway resistance
- Increased sputum IL-8 levels
- No apparent airway inflammation
- Increased epithelial staining for IL-10

CLINICAL EFFECTS OF DEPS IN NASAL PROVOCATION

A. Immediate-phase response (minutes)

- Increases allergen-induced histamine release and symptoms

B. Short-term response (hours)

- Increases release-production of C-C chemokines
- Increases cellular inflammation
- Induces a potent TH2 cytokine milieu in the presence of antigen
 - (eg, increased IL-4 and decreased IFN-g levels)

C. Intermediate-term response (days)

- Enhances total and allergen-specific IgE responses to antigen
- Increases number of IgE-secreting cells in nasal mucosa

D. Long-term response (days)

- Enhances primary allergic sensitization

Riedl, M. et al. Biology of Diesel Exhaust Effects on Respiratory Function. *Journal of Allergy and Clinical Immunology*; 115: 221-226. 2005.

K - TH1 - TH2 DEFECT

Figure 16 - Existence of susceptible patient subsets more prone to pollutant health effects

This 2004 review from the AAAI's *Journal of Allergy and Clinical Immunology*, serves an important purpose in separating out the different subsets of patients who report chemical sensitivity to pollutants normally tolerated by healthy individuals.

Apart from this group of patient subsets, there exists an entirely separate group of patients that are diagnosed with multiple chemical sensitivity syndrome, who do not claim any allergic-immune problems and represent a wastebasket for patients with a syndrome of unknown etiology. The toxicology patients who report chemicals sensitivity and pollutant health effects fall into Tier 3, which can be accompanied by apoptosis and necrosis and end organ failure.

Our patients fall squarely in Tier 2 where inflammation and swelling underlie significant clinical illness. There is an underlying genetic predisposition. The biological outcome is both Th1 and Th2 cytokine mediated.

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Existence of susceptible patient subsets more prone to PM-induced airway disease

Mechanisms by which air pollutants cause adverse health effects are complex. Reactive PM sequentially induce protective and injurious cellular responses. Oxidative stress accumulation of oxidized glutathione and a decrease in the glutathione/oxidized glutathione ratio.

Oxidative stress initiates redox-sensitive signaling pathways (ie, mitogen-activated protein kinase) synergistically to activate proinflammatory cytokine, chemokine, and adhesion receptor expression.

A weakened antioxidant defense could increase the propensity toward PM-induced airway disease. There are susceptible human subsets, who are more prone to experience adverse health effects due to normal antioxidant defense. Our patients with abnormal Th1 - Th2 cytokine immunmodulation.

LEVEL OF OXIDATIVE STRESS



Response Tier	Anti-oxidant defense
Response Pathway	↑ Nrf release to the nucleus
Genetic Response Element	anti-oxidant response element
Biological Outcome	phase II & anti-oxidant enzyme expression
Clinical response	weakened response >> susceptibility

Bernstein JA et al; Health Effects of Air Pollution; Journal of Allergy & Clinical Immunology 2005; 165(5): 1121-1131

· prone to pollutant health effects

ctive oxygen species can cause inflammation. Incremental doses of stress is defined as a depletion of intracellular glutathione, leading to a thione ratio.

lated protein kinase and the nuclear factor kB cascade), which work together to express through appropriate genetic response elements.

airway inflammation, increased susceptibility to infection, and asthma. These health effects during pollutant exposure compared with persons with a modulatory regulation fall into the Tier 2 inflammation group.



low
GSH/GSSG
ratio

use Inflammation

Toxicity

NF-**kB** & MAPK activation

mitochondrial perturbation

NF-**kB** & AP1 response elements

apoptosis
necrosis

cytokines
chemokines
adhesion mols

? airway
hyperreactivity

>> asthma
adjuvant effects,
? atherosclerosis

K - TH1 - TH2 DEFECT

THYROID

Figure 17 - Th1 cytokine response in concomitant thyroid disease

60. One of the ways we have been able to elucidate the immunobiological underpinnings of clinical disease in patients with multiple medical problems is to analyze epidemiologically what are the most frequent concomitant diagnoses. Over a 23 year period I shared most of my patients and their families with thyroidologist, Boris Catz, M.D., former Chairman of Endocrinology at Cedars Sinai Medical Center, and his colleague radiologist James Pritchard, M.D.. Some of these patients also saw Cedars thyroid surgeon physician, Mitchell S. Karlan, MD, FACS Past President of the CMB and Past President of the LACMA.

61. It became clear early on that there was a very disproportionate incidence of concomitant thyroid disease in my patients with this Th1-Th2 immunoregulatory defect.

Dr. Catz observed that even the hypothyroid patients with negative thyroid antibodies still presented clinically as Hashimoto's thyroiditis patients. This was consistent with the fact that there is a very high % of false negatives in thyroid antibody tests, particularly years ago because they were based on response to animal

K - TH1 - TH2 DEFECT

tissue. There was no increased incidence in our patients of Grave's disease.

62. Subsequently, after Th1 and Th2 cytokine pathways were elucidated in 1986, we now know that Hashimoto's thyroiditis is primarily Th1 mediated and this was consistent with the excellent response of our patients to TF which involves Th1 cytokines in an immunologically distinct cytokine pathway from patients with Grave's disease.

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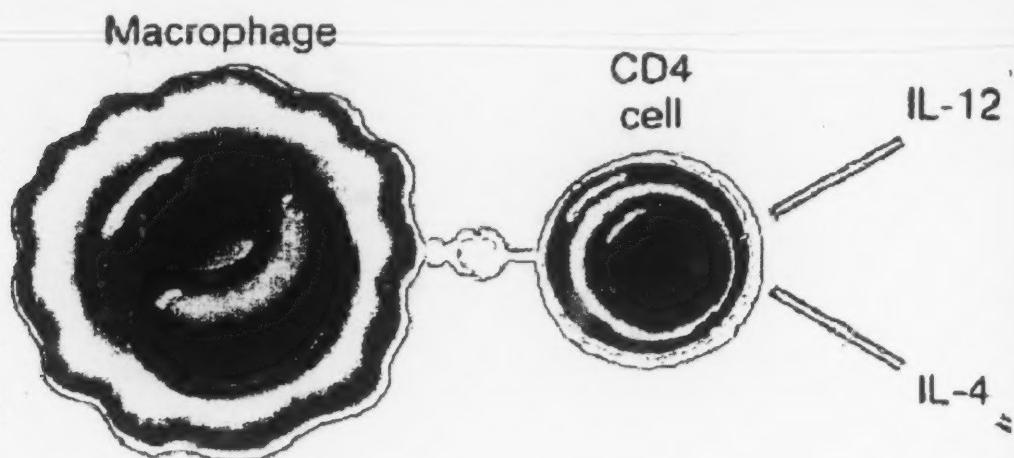
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Th1 cytokine response in concomit

Most of our patients with extensive allergies , including allergic hypersensitivity to chemicals , and abnormal cell mediated immunity were independently evaluated by Boris Catz, M.D. former Chairman of Endocrinology, Cedars-Sinai Medical Center and his colleague James Pritchard, M.D., over a 23 year period. They found an unusually high rate of concomitant hypothyroidism, goiter and Hashimoto's thyroiditis [Th1 mediated], but not Graves disease [Th2 mediated].

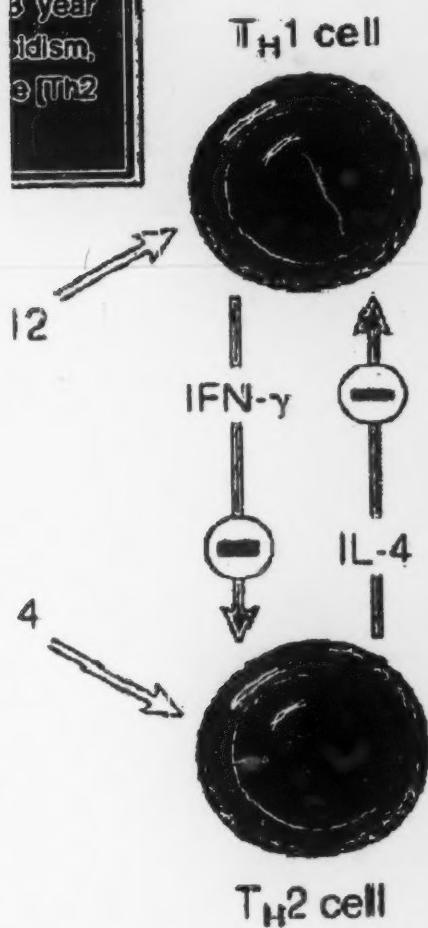


Kumar: Robbins and Cotran: Pathologic Basis of Disease, 7th Edition Saun

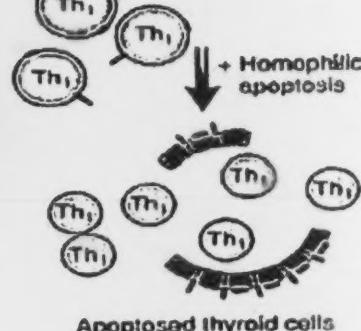
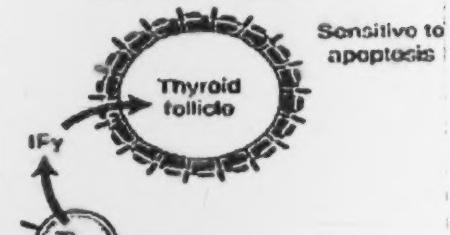
Kronenberg: Williams Textbook of Endocrinology, 11th Edition 2008 Si

Thyroid disease

Slitvly
Gently
Sina
3 year
dism,
3 μm²



Hypothyroidism



saunders 2005 (above)

8 Saunders (right)

K - TH1 - TH2 DEFECT

Figure 18 - Release of hypothalamic hormones shifts

Th2 response to detriment of Th1 responses

63. This 2008 figure from Dermatologic Therapy shows the immunobiologic pathway of what we see clinically in the course of private practice. Patients will come in diagnosed with adrenal and other endocrine dysregulation with corroborating lab findings. When the stress of the combined Th1 – Th2 immunoregulatory defect is treated with PF antigens and TF, we see these adrenal and other glandular dysregulations spontaneously remit, and the laboratory values return to normal without relying on steroids, or other hormonal therapies. Many of these patients had already been through hormonal therapy with top endocrinologists which almost invariably caused more clinical problems and no relief.

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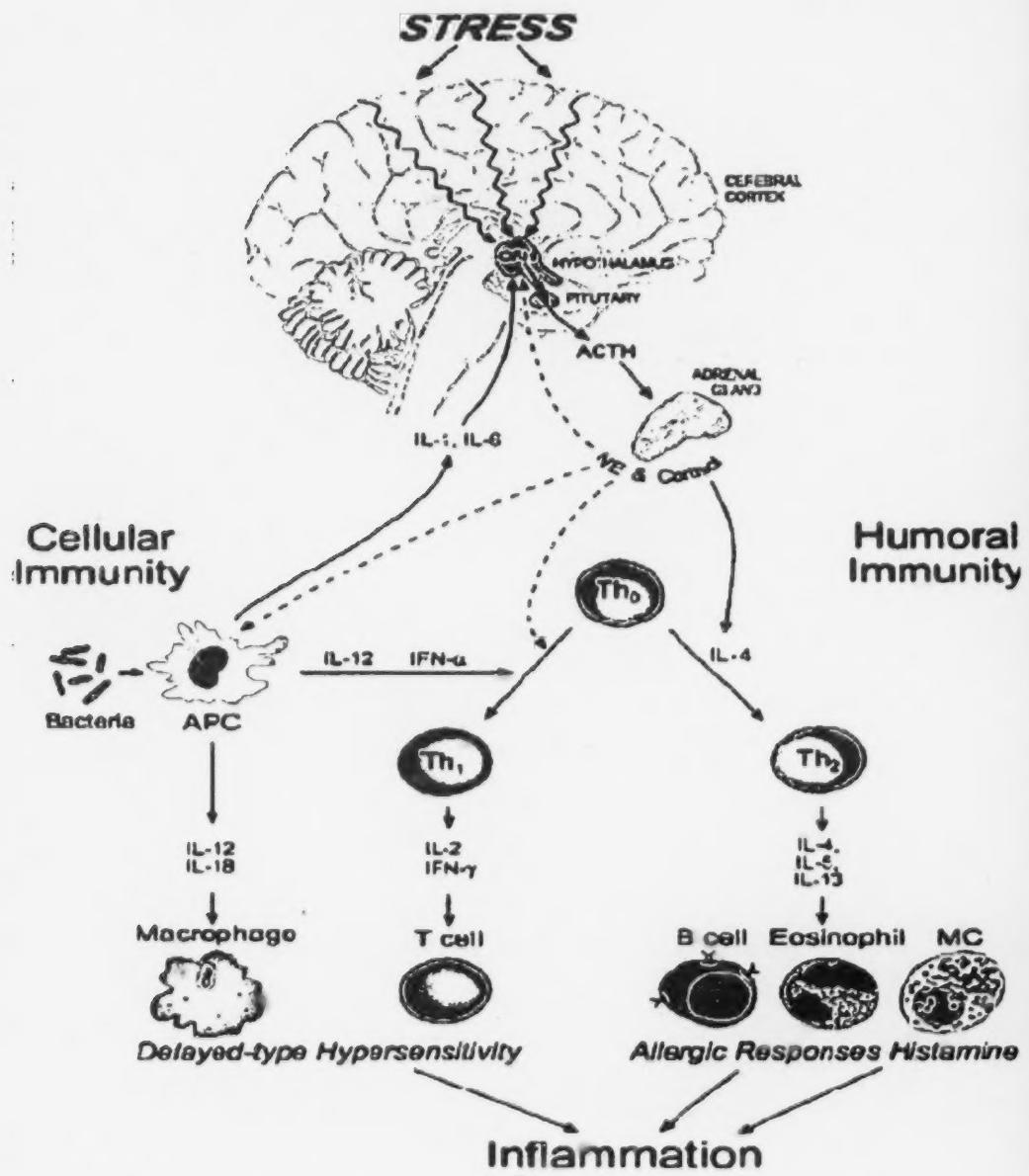
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Release of hypothalamic hormones shifts Th2 response



use to detriment of Th1 responses

1. Stressors are processed through the hypothalamus resulting in the release of CRH, ACTH, NE and eventually cortisol.
2. The latter hormones mediate the differentiation of Th0 (naïve T Helper cells) towards the Th2 humoral immune response to the detriment of the Th1 cell-mediated response.
3. APC's secrete cytokines that mediate Th1 differentiation, however the presence of bacterial products such as LPS that bind to Toll-like Receptors induce the production of IL-1 and IL-6, which cross the blood-brain barrier and trigger the hypothalamic CRH-stress response.
4. In this manner, a blood borne stressor of infectious nature can activate the HPA axis. Th1 effects are mediated by the cytokines IL-12, 18,2 and gamma-Interferon and T cells and macrophages.

Th2 responses are mediated by IL-4,6,13 and B cells, eosinophils and mast cells.

CRH: corticotropin releasing Hormone;

NE: norepinephrin;

Th0: naïve Helper cells;

APC: antigen presenting cell;

LPS: lipopolysaccharide;

HPA: hypothalamic-pituitary-adrenal axis.

K - TH1 - TH2 IMMUNE
DEFECT

INFECTION

Figure 19 - Differentiation of Th1 and Th2 & their cytokine functions in infection

64. Infection provides more clues as to underlying immunopathology. Our patients with recurrent infections clinically fall into the Th1 cytokine mediated pathways shown at the top of this figure from Cohen's 2004 edition of Infectious Diseases.

65. They do not present with the infections seen in severe combined immunodeficiencies and so forth. A number of these patients have been previously treated with IV or SQ gammimmune for prolonged periods with no clinical response, as would be expected because this Th1 - Th2 cytokine defect is a different arm of the immune system.

66. The TF has been extremely efficacious in helping our patient subset with recurrent infection such that they had far fewer or even no further infections. When they have an infection they recover without intervention or respond more appropriately to antimicrobials, when previously they could not.

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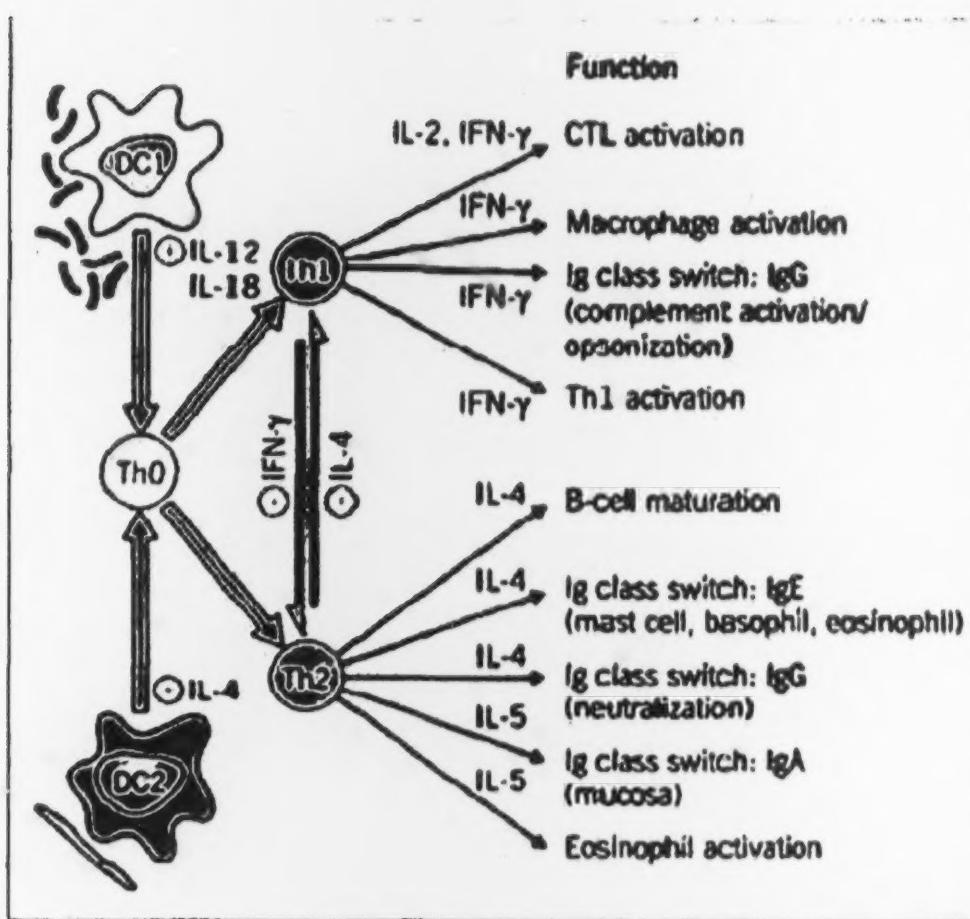
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Differentiation of Th1 and Th2 and their cytokine functions



Cohen & Powderly: Infectious Diseases; 2nd ed.; Mosby; 2003

no functions in infection

Protection against

**Viruses, some intracellular microbes
(Listeria, Trypanosoma spp.)**

Intracellular microbes

Extracellular microbes

All microbes, viruses

**Extracellular microbes, virions,
helminths**

**Helminths
(sinophil)**

Virions, toxins

Numerous pathogens

Helminths

; Mosby; 2004; Figure 97.4.

PRESERVATIVE-FREE
ANTIGEN IMMUNOTHERAPY

Figure 20 - Role cytokine IL-10 plays in
Th2 antigen immunotherapy response

67. The left shows the currently elucidated IL10 mechanism for the effect of antigen immunotherapy from the Journal of Allergy and Clinical Immunology 2004. Antigen immunotherapy has been used for many, many decades based on clinical medicine observations and documentation. Although there may be difference in techniques for different patient subsets, particularly for the food allergy patients, but the administration of tiny amounts of the antigen the patient is hypersensitive to remains constant.

68. The right shows the biphasic early, intermediate and late response to antigens and the associated morphological immune response. The difficulty with our patient subset with a combined Th1 – Th2 immunoregulatory defect is that they have become immunologically intolerant to too many things that cause overlapping symptoms and morphologic changes for up to 72 hours. And that presumes normal digestion times and functioning. It is impossible for patients to clinically discriminate so many reactions that are cumulative, additive and synergistic. They are overwhelmed trying phy

K - TH1 - TH2 DEFECT

sician-prescribed avoidance techniques, when the acute reactions morph into chronic symptoms and then end-stage organ damage.

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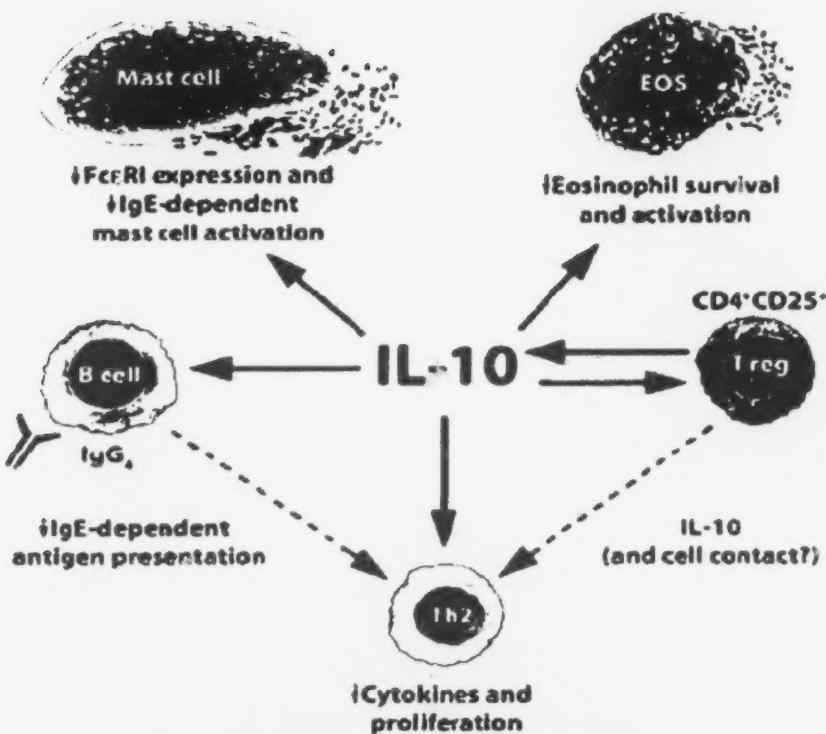
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Role cytokine IL-10 plays in Th2 an



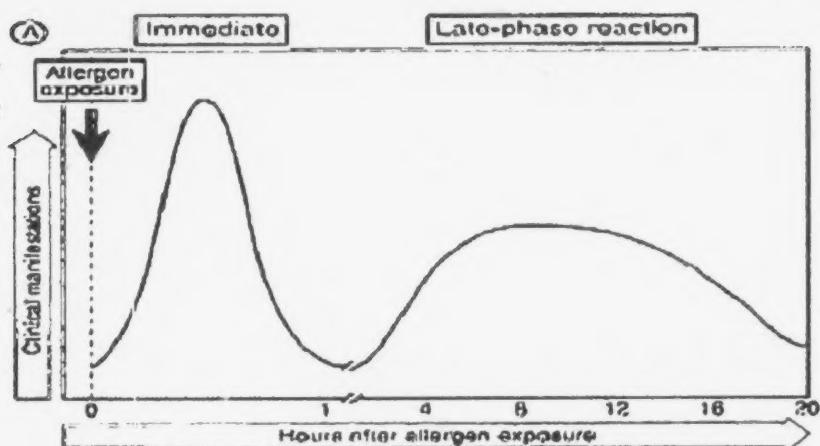
Potential anti-allergic properties of IL-10 on different limbs of the allergic immune response

The cytokine IL-10. Recent studies have identified increased IL-10 production in peripheral blood and mucosal surfaces after antigen immunotherapy. IL-10 has numerous potential anti-allergic properties, including suppression of mast cell, eosinophil, and T-cell responses, as well as acting on B cells to favor heavy chain class switching to IgG4. The relationship between a Th2 to Th1 shift and induction of IL-10 is still being studied.

EOS, Eosinophil; T reg, T regulatory cell.

Till SJ, Francis JN, Nouri-Aria K, Durham SR.; Mechanisms of Immunotherapy;
J Allergy Clin Immunol 2004; 113:1025-1034

Antigen immunotherapy response



Immediate & late reactions In the allergic immune response

Kinetics: of the immediate and late-phase reactions (A) The immediate vascular and smooth muscle reaction to allergen develops within minutes after challenge (allergen exposure in a previously sensitized individual), and the late-phase reaction develops 2 to 24 hours later.

Morphology: of the immediate reaction (B) is characterized by vasodilation, congestion, and edema, and the late phase reaction (C) is characterized by an inflammatory infiltrate rich in eosinophils, neutrophils, and T cells.

Kumar: Robbins and Cotran: Pathologic Basis of Disease,
7th Edition Saunders 2005

K - TH1 - TH2 DEFECT

TRANSFER FACTOR IMMUNOMODULATORY THERAPY

Figure 21 - Transfer factor activates Th1 cells in transfer factor recipients

69. In addition to our own Daubert-qualified transfer factor expert, Alan S. Levin, M.D., J.D., Dr. Charles Kirkpatrick, Professor of Medicine, Director of the Adult Allergy-Immunology program at University of Colorado Health Sciences Center at Denver and National Jewish has also weighed in. He affirms that his ongoing work affirms that there are many transfer factors and predominant players are Th1 cytokines particularly, IFN-g. But the real advantage of TF is that it is physiologically unique to the 33 donors and can confer a panoply of improved immunologic response unique to the needs of the recipients.

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Transfer factor activates Th 1 cells in tr



Charles H. Kirkpatrick, MD
Professor of Medicine and Immunology
University of Colorado at Denver
Health Sciences Center
Division of Allergy & Clinical Immunology
Director, Adult Immunodeficiency Program

From his transfer factor citations:
1, 5, 6, 7, 9, 48, 70, 103-124,
178, 186, 187, 194, 212, 239

Transfer factor contains many trar

- 1.) are proteins that transfer the donors to non-immune recipient.
- 2.) activate T helper type 1 cells (T1)
- 3.) activate the effect or mechanism the B cell functions
- 4.) cause antigen-specific productic migration inhibitory factor by the recip
- 5.) increase lymphocyte proliferation
- 6.) increase activity of cytotoxic T ce
- 7.) endows the recipients' spleen ce antigen in vitro by secreting gamma-
- IL- 10
- 8.) have small molecular weights (i immunoglobulins, major histocomp receptors
- 9.) like immunoglobulins, bind to in

- 10.) reduction and alkylation of transfer factors does not dissociate thei
- 11.) T-lymphocyte receptors do not bind intact antigen molecules as transferred to recipients of transfer factors are mediated by T lymphocyt
- 12.) have a conserved or constant region that may serve as a binding s
- 13.) have a novel amino acid sequence, LLYAQDLVEDN identifies peptides do not transfer expression of delayed-type hypersensitivity to expression of the specificity or immunological properties of native trar recipients of native transfer factors blocked expression of delayed-type immuno suppressive. These findings are consistent in that the peptides the target cells for transfer factors.

ells in transfer factor recipients

many transfer factors, predominantly cytokines (Th1):

transfer the ability to express cell-mediated immunity from immune patient.

T cells (Th1) in transfer-factor recipients.

mechanisms of the cell-mediated immune system, with no effects on

production of macrophage migration inhibitory factor or leukocyte by the recipients' peripheral blood mononuclear cells.

proliferation demonstrated by the thymidine-incorporation assay

cytotoxic T cells

spleen cells with the property of responding to the corresponding gamma interferon, but not production of interleukin IL-2, IL-4 and

weights (molecular mass E 5000 Daltons) are quite different from histocompatibility complex (MHC) molecules and T-lymphocyte

bind to intact antigen molecules

associate them into heavy chains and light chains

molecules as transfer factors do, yet the immune responses that are lymphocytes.

binding site for cells that are primary targets

I identified in each of seven transfer factor preparations. These sensitivity to recipients. This indicates that they are not sufficient for native transfer factors. However, administration of the peptides to delayed-type hypersensitivity by the recipients. The peptides were not peptides may represent the portion of transfer factors that binds to

K - TH1 - TH2 DEFECT

Figure 22 - Transfer factor inducer-helper activity & suppressor factors

70. We see the many identified low molecular weight components in pooled TF obtained from healthy donors. What one donor may be deficient in, will not be deficient in most of the other donors. The TF peer-reviewed work from Finland showed that <10% of health donors had anergy to TB for example, and that pooled TF overcomes any deficiency of a single donor.

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K - TH1 - TH2 DEFECT

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Transfer factor inducer-helper activity

Transfer factor Inducer-helper activity

- binds to specific antigen but not to specific antibody
- recovered from antigen; immunoabsorbent with gm urea
- binds to anti-VH but not to anti-VK antibody
- binds to anti-Ia but not B2-microglobulin antibody
- resides in Th cells but not Ts cells
- absorbed by Ts cells and by macrophages
- found in >3500, >12,000-Dalton dialysis fraction
- equips nonimmune cells with antigen-binding moiety
- dialysable fragment of Th cell antigen receptor

Suppressor factor - Anti-transfer factor

- binds to specific antibody IgG but not to specific antigen
- recovered from IgG; immunoabsorbent with glycine-HCT
- binds to anti-VK, but not Anti-VH antibody
- binds to anti-Ia but not anti-B2-microglobulin antibody
- resides in Ts cells and not TH Cells
- absorbed by TH cells and by macrophages
- found in >3500, >1 2,000-Da dialysis fraction
- blocks inducer-helper activity of TF on non-immune cells
in a dose-dependent fashion
- abrogates responses to immune cells to specific antigen
in vitro
- suppresses footpad response in immune BALB/c mice *in vivo*
- dialysable fragment of anti-idiotypic T-cell receptor

activity & suppressor factors

Transfer Factor is a very low molecular weight extract of pooled white blood cells from screened donors. There are many constituent transfer factors. TF is safe, as the processing includes many barriers include: freeze-thaw cycles, multiple filtrations, gassing/freeze-drying etc. This produces a safe, contaminant-free injectable inert extract. It has a sixty-year track record of complete safety, even in patients with severely compromised immune systems. Viral and other infectious diseases are not transmitted through transfer factor. TF is specific in activating / restoring delayed type hypersensitivity / cell mediated immunity. Different patients naturally absorb different transfer factors depending on their underlying immunoregulatory defect, as the body attempts to reestablish homeostasis.

Nonspecific Biochemical Components of TF

- polypeptide-nucleotide 5'-IMP
- hypoxanthine
- uracil
- nicotinamide
- ascorbic acid
- vasoactive mediators
- inflammatory mediators
- serotonin
- histamine
- bradykinin
- prostaglandins
- T-lymphocyte maturation or differentiation factors
- thymosin
- chemotactants for monocytes
- neutrophil immobilizing factors

K - TH1 - TH2 DEFECT

Figure 23 - Th cell differentiation and cytokine pathway is the same in humans and mice

71. Studies in rodents are not automatically good correlates for humans. For example, murine gene studies which transferred the cystic fibrosis gene led to the development of the liver disease of CF but not the critically important lung disease.

72. After H. Sherwood Lawrence, M.D., first identified the powerful clinical response of patients with abnormal cell mediated immunity – delayed type hypersensitivity, he was pressured by peers to corroborate the findings in rodents, which he and others eventually did.

73. Our most recent understanding of Th1 and Th2 is published in Allergy: Allergology International in 2008 shows the close correlate between Th1 and Th2 cytokine responses in humans (left) and mice (right).

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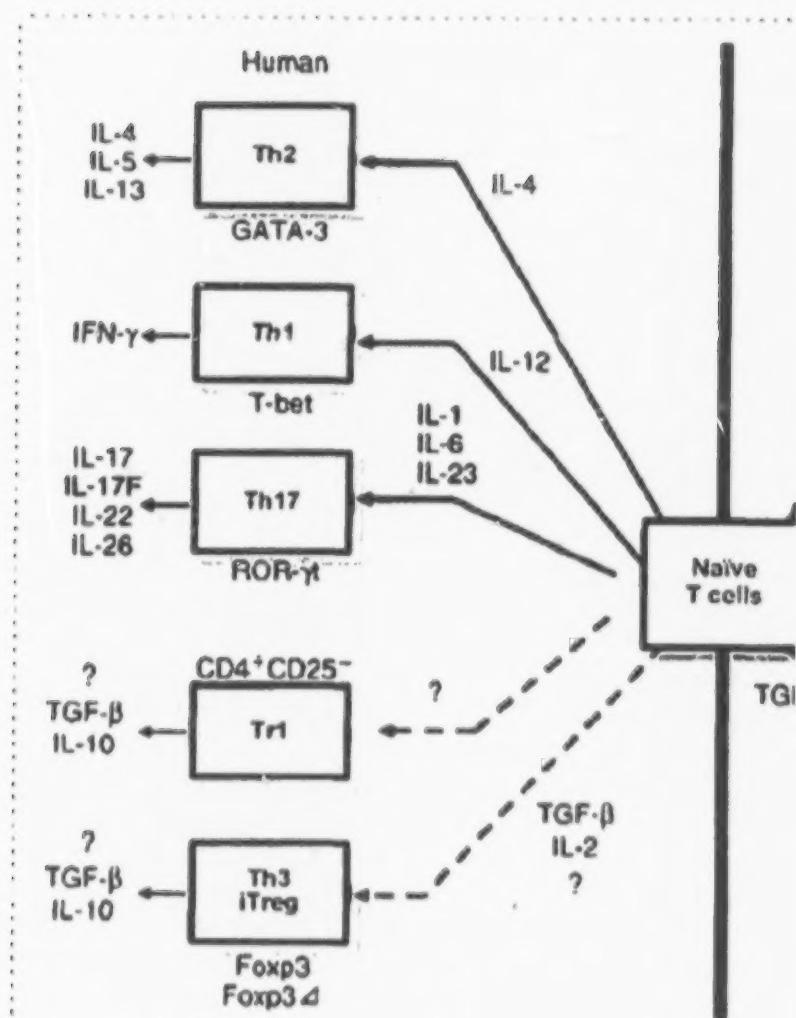
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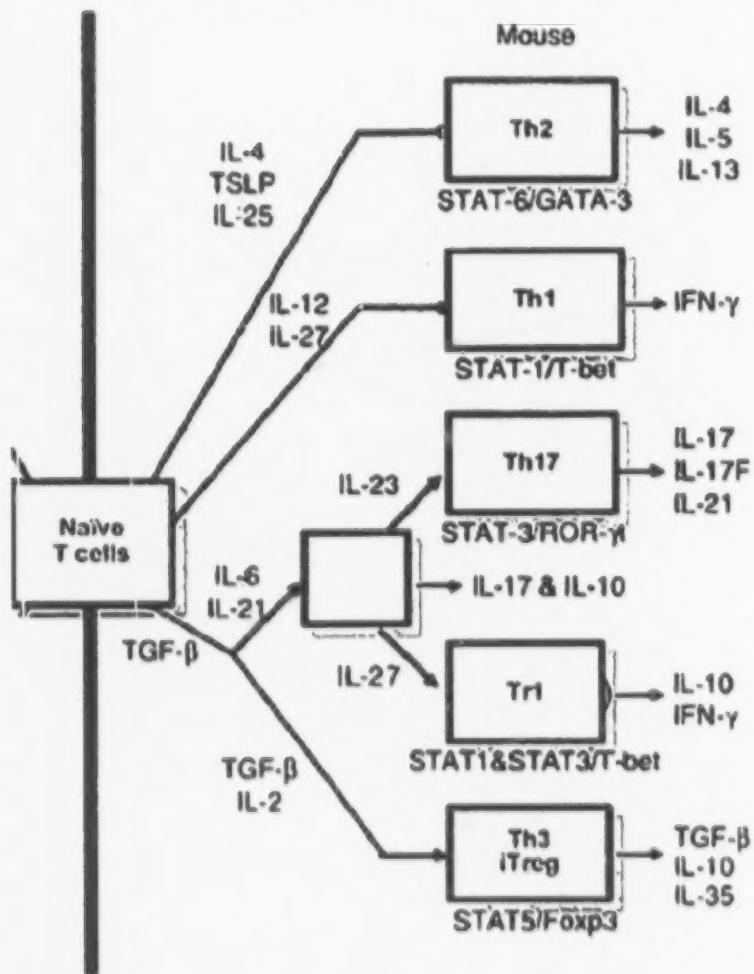
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Th differentiation and cytokine production



Obeki, K.: Th17 and Allergy; Allergology In

Cytokine production in humans and mice



K - TH1 - TH2 DEFECT

Figure 24 Transfer of a healthy cell mediated immune response after transfer factor

74. In 1974 Annals of Internal Medicine, we see two identical mice who had never been exposed to Dinitrochlorobenzene [hereinafter DNCB]. DNCB is an organic chemical that causes a contact immune response that is easily measured. The mouse on the left, was given TF and only then able to mount a 5+ immune response to DNCB. The mouse on the right, who did not receive transfer factor was unable to mount an immune response.

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Transfer of a healthy cell mediated immu

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The mouse in A was injected intraperitoneally with 0.125 ml of DNCB (1-chloro-2,4 dinitrobenzene) transfer factor derived from guinea pigs. 48 hours later the mice were shaved and challenged with 1% DNCB solution. By 36 hours after the challenge this mouse that received the TF developed a 5+ reaction.

Transfer factors are remarkable substances that transmit immunologic information.

In chronic mucocutaneous candidiasis, patients have a persistent Candida infection. Patients are unable to mount a cellular immune response to the candida antigen. Leukocytes of individuals who are able to respond to the candida antigen.

Twenty one of the patients converted to a candida-reactive state, and 14 showed remission.

Another striking example of successful immunotherapy is the case of Wiskott-Aldrich syndrome. In carefully controlled experiments, patients with the Wiskott-Aldrich syndrome were given dialyzable material obtained from normal individuals. The patients responded to the therapy.

For periods of up to 6 months, there was an absence of infections and, simultaneously, to which the donor had been responsive. Both the clinical improvement and the response to the therapy were maintained by repeated therapy.

Potter, H et al; Transfer Factor, Annals of Internal Medicine, 1970, 73(5), 735-740.

immune response after transfer factor



The mouse in B received 0.125 ml. of 3M. NaCl as a control. 48 hours later the mice were shaved and challenged with 1% DNCB solution. By 36 hours after the challenge, this control mouse showed no reaction.

nation from 'educated' leukocytes to 'naive' leukocytes.

infection involving lesions in the skin, nail, scalp, and mucous membranes. Most antigen. Twenty five such patients were given transfer factor prepared from the

showed marked clinical improvement with eradication of the disease or sustained

Witt-Aldrich syndrome. This is a severe immunodeficiency characterized by a general experiments. Spitzer, Levin and colleagues have treated several patients with Wiskott A. The results were dramatic.

multaneously, the recipients were converted to a positive test response for antigens if the specific examples of acquired immune responsiveness could be maintained by

K - TH1 - TH2 DEFECT

Figure 25 - Reproducible transmission of cell mediated immunity with transfer factor

75. In a 1974 Harvard study published in the Proceedings of the National Academy of Sciences, we see that TF consistently confers cell mediated immunity to DNCB and OCBC (ortho-chlorobenzoylchloride) in naïve guinea pigs. The controlled study shows a clear and consistent response from TF and the response is TF dose specific.

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Reproducible transmission of cell me



FIG 2. (above) Reactive site (2a) compared to an adjacent area not exposed to antigen (2b). The lymphoid tissue from animals in (1) & (2) is the source of the TF.

FIG 3. (right) Acquired immune capacity of two naive animals that received injections of TF, and the reactivity of a third animal that was mock injected with a saline solution. Upon challenge with DNCB (1st exposure to antigen) test animals mounted secondary responses.

(1) The animal on the left, which received TF from 1/4 of a donor, was able to produce very strong delayed type hypersensitivity responses upon challenge with antigen. The reactions are scored as +5, being characterized by homogeneous necrosis of the affected region, plus erythema and induration.

(2) The middle animal received TF from 1/8 of a donor & was able to give a + 4 response (patchy necrosis) to the higher test solution of antigen used, and a + 3 response (erythema & induration) to a lower test solution of antigen.

(3) The control animal is on the right, which received a saline solution and was not able to give a response upon challenge with antigen.



Rosenfeld, S.; Transfer Factor: A Subcellular Component t
Proceedings of the National Academy of Scier

mediated immunity with transfer factor

FIG. 1. (left) Immune capacity developed in an animal that has been directly exposed to antigen (DNCB or OBCB). Six days after antigen was painted on the ear, the back of the guinea pig was shaved and the antigen was applied again. This provoked the secondary response (a delayed hypersensitivity reaction) shown. The reaction is designated + 2 in severity; it is characterized by a homogenous erythema representing an increased blood supply in the area where responding leukocytes are eliminating the antigen.



Fig. 4 (left) Data concerning the specificity of the immune responsiveness transmitted by transfer factor. This animal has been injected with TF prepared from donors that had been sensitized to give a delayed hypersensitivity response to OCBC. The animal that received the TF was then challenged with both DNCB and OCBC; he responded only to OCBC (upper flank). The response is + 3 in severity (erythema and induration).

Fig. 6 (left) The swelling component of the reaction in Fig 4 is particularly well displayed here, where the reaction site has been pinched.

that Transmits Information for Specific Immune Responses;
ences, Vol. 71, No. 6, pp. 2473-2477, June 1974

K - TH1 - TH2 DEFECT

Figure 26 - Identification of conserved sequences in transfer factor molecules

76. In 2000, Dr. Charles Kirkpatrick identified individual conserved sequences of the constituent transfer factors in TF. A novel amino acid sequence was identified LLYAQDLVEDN, was identified in each of seven transfer factor preparations. This allows further demonstration of the antigen-specificity of transfer factors.

77. These peptides did not have TF activity.

78. They did block expression of cell mediated / delayed-type hypersensitivity.

79. The peptides may represent the portion of transfer factors that binds to the "target cells" for transfer factors. The TFs may operate through a unique mechanism of antigen presentation & T-cell activation.

80. This elegant study adds to our understanding of Th1 cytokine immunobiology, just as all ongoing Th1 cytokines studies add to our understanding of TF.

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Identification of conserved sequences

We developed a process for purifying specific transfer factors to apparent homogeneity. This allowed us to separate individual transfer factors from mixtures containing several transfer factors and to demonstrate the antigen-specificity of transfer factors. A novel amino acid sequence, LLYAQDL/VEDN, was identified in each of seven transfer factor preparations.

These peptides would not transfer expression of delayed-type hypersensitivity to recipients, which indicates that they are not sufficient for expression of the specificity or immunological properties of native transfer factors. However, administration of the peptides to recipients of native transfer factors blocked expression of delayed-type hypersensitivity by the recipients. The peptides were not immunosuppressive. The peptides may represent the portion of transfer factors that binds to the "target cells" for transfer factors.

Fig. 2.
Inhibition of delayed type hypersensitivity by recipients of TF by administration of LLYAQDLEDN.

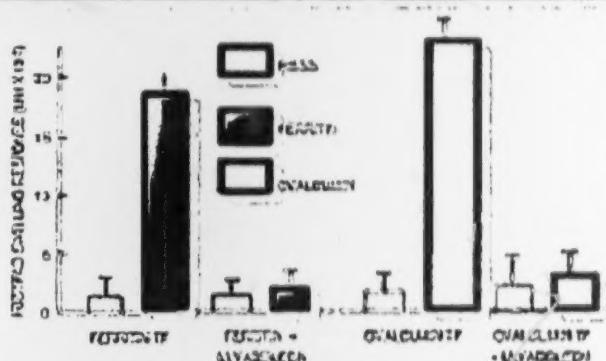
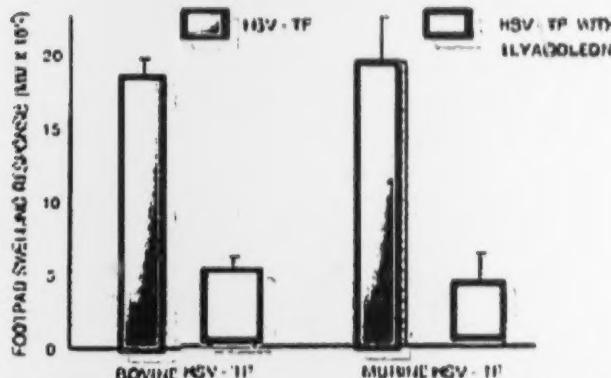


Fig. 3.
Inhibition of expression of delayed type hypersensitivity to Herpes simplex by LLYAQDLEDN.



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Kirkpatrick, C.H., Transfer Factors: Identification of Conserved Sequences in Transfer Factor Molecules; Molecular Medicine; 6(4): 332-341, 2000

Differences in transfer factor molecules

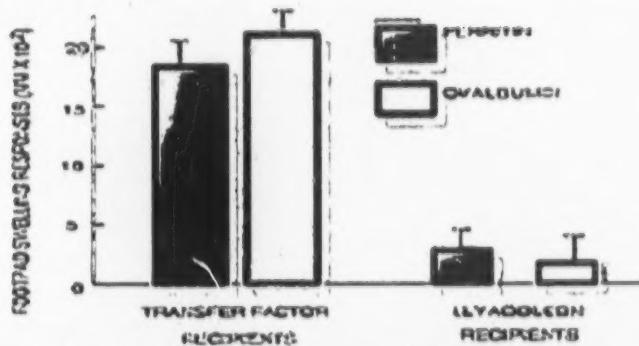


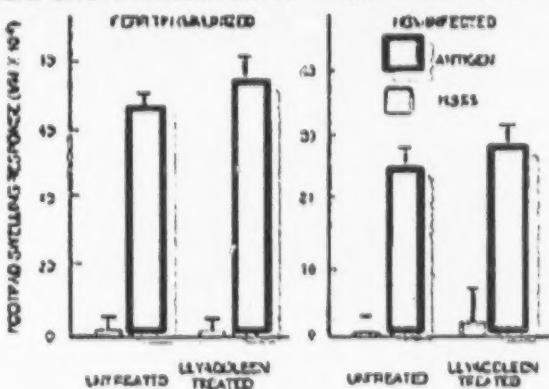
Fig 1. Does the peptide LLYAOOLEON have transfer factor activity?

The small molecular weights of transfer factors (molecular mass ~ 5000 Da) are quite different from immunoglobulins, major histocompatibility complex molecules and T-lymphocyte receptors. Like immunoglobulins, transfer factors bind to intact antigen molecules, but reduction and alkylation of transfer factors does not dissociate them into heavy chains and light chains.

T-lymphocyte receptors do not bind intact antigen molecules as transfer factors do, yet the immune responses that are transferred to recipients of transfer factors are mediated by T lymphocytes. TFs may operate through an unique mechanism of antigen presentation & T-cell activation.

Transfer factors can be used to reconstitute cellular immunodeficiency in clinical settings without affecting the recipient's ability to develop protective immune responses after infections or immunizations.

Fig. 4.
Effect of
LLYAOOLEON
on expression of
delayed type
hypersensitivity
by immunized mice.



K - T H 1 - T H 2 D E F E C T

Figure 27 - Profiles of Th1 and Th2 cytokine production in recipients of transfer factor

81. In 1996, using herpes simplex virus (HSV) specific TF, Dr. Charles Kirkpatrick proved that activation of Th1 and possible suppression of Th2 is an immunologic mechanism that is activated in TF recipients. These findings affirm Dr. Lawrence's original 1954 work, long before these exact immunologic mechanisms were elucidated.

82. Even though TF can be extremely specific for HSV, it does not mean that a single one of the many transfer factors in TF is exclusively responsible for the clinical improvement for any individual patient.

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Profiles of Th1 and Th2 cytokine production

Transfer factors are proteins that transfer the ability to express cell mediated immunity from immune donors to non-immune recipients. The study shows that activation of the T helper type 1 cell Th1 is an immunologic mechanism that is activated in TF recipients.

BALB/c mice were sensitized to Herpes Simplex Virus (HSV) by administration of HSV-specific transfer factor. Single cell suspensions from their spleen were collected one week later. Spleen cells from infected mice responded to concanavalin A and to HSV by producing large amounts of IL-2 and IFN-gamma.

2. Th1 cytokine profiles

	IFN-gamma (pg/ml)		IL-2 (pg/ml)	
	Con-A	HSV	Con-A	HSV
Systematically sensitized mice	48,900	8,900	8,500	500
TF (systemic) recipients	124,000	14,000	10,500	0
Cutaneously sensitized mice	333,000	75,000	20,000	6,750
TF (cutaneous) recipients	154,000	26,000	15,465	0
Control	5,400	0	9,000	0

Transfer factor recipients produced similar cytokine profiles in response to concavalin A. These mice, however, responded to HSV by secreting IFN-gamma but no IL-2. Transfer factor treatment selectively affects cytokine production in response to antigenic stimulation. The selective activation of Th1-mediated responses may also be accompanied by inhibition of Th2-mediated responses.

TF may induce large amounts of IL-12 by either activating a large number of Th1 cells or by causing increased cytokine production, by selectively activating Th1 cells, which in turn stimulate the production of large amounts of IFN-gamma. IL-12 has been described as natural killer cell stimulatory factor.

tion in recipients of transfer factor

1. Time course of cytokine production (TF control Con-A)

IFN-gamma pg/ml	3700	5400
IL-2 pg/ml	9100	5850
IL-4 pg/ml	224	200
IL-10 U/ml	0.03	0.05

3. Th2 cytokine profiles

	IL-4 (pg/ml)		IL-10 (pg/ml)	
	Con-A	HSV	Con-A	HSV
Systematically sensitized mice	0	0	4.95	1.44
TF (systemic) recipients	85	0	0.9	0.2
Cutaneously sensitized mice	0	30	1.1	1.0
TF (cutaneous) recipients	105	0	1.0	0.01
Control	200	2	0.05	0.01

In addition to the activation of Th1 cells, underlying the effects of transfer factors can be the already well recognized natural and specific immune responses to viruses, including type 1 interferons, and CD8 class I restricted cytotoxic T lymphocytes.

The present data suggest that TF recipients develop a Th1 cytokine phenotype. IFN-gamma was the predominant cytokine produced.

Alvarez-Thull, L. Kirkpatrick, CH; Profiles of cytokine production in recipients of transfer factors; *Biotherapy*; 9: 55-59, 1996

K - TH1 - TH2 DEFECT

Figure 28 - Clinical and lab improvement in patients with combined Th1 & Th2 defect treated with TF

83. This study was done by Dr. Youdim, who set up my TF program and worked beside me as my mentor and colleague in my practice for years. Dr. Youdim started his work on TF at the University of Minnesota Medical Center with Robert A. Good, M.D., Ph.D. Dr. Good performed the first successful human bone marrow transplant and is regarded as a founder of modern immunology.

84. These results are consistent with the 75% + significant clinical improvement we see in our otherwise refractory patients with a combined Th1 - Th2 immunoregulatory defect. My focus is not myopically focused on a specific symptom, but primarily on a patient's ability to perform activities of daily living. If we can get one failing organ system better, such as relieving severe asthma, but the patient still struggles with self-care and normal activities that healthy patients take for granted, we have failed that patient. We can do both with combined Th1 & Th2 immunotherapy - PF antigens and TF.

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K - TH1 - TH2 DEFECT

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Clinical and laboratory improvement in patients with com

Table 39.4 Improvement in clinical status of 50 patients with extensive allergies, including allergic hypersensitivity to chemicals, and abnormal cell mediated immunity after 6-12 months of transfer factor

Symptoms	Moderate decrease	Substantial decrease	No change	Total # patients tested	Total # of patients improved
Allergy & hypersensitivity	27 pts 54 %	6 pts 12 %	17 pts 34 %	50	33
Cephalgia	13 pts 32 %	9 pts 22 %	19 pts 46 %	41	22
Recurrent infection	16 pts 36 %	10 pts 23 %	18 pts 41 %	44	26
Fatigue	19 pts 39 %	15 pts 31 %	15 pts 31 %	49	34
Lack of concentration	16 pts 37 %	12 pts 28 %	16 pts 35 %	43	28
Arthritis	9 pts 33 %	3 pts 11 %	15 pts 56 %	27	12
Gastrointestinal problems	12 pts 41 %	3 pts 10 %	14 pts 48 %	29	15
Depression	12 pts 37 %	7 pts 22 %	13 pts 41 %	32	19

mbined Th1 & Th2 defect treated with transfer factor

Table 39.5 Improvement of immune parameters & overall clinical status patients with extensive allergies, including allergic hypersensitivity to chemicals, and abnormal cell mediated immunity after 6- 12 months of transfer factor

Laboratory testing	# of patients tested	# of patient improved	Percent
WBC	27	18	66.7
Lymphocytes	27	18	66.7
T 11	27	18	66.7
T4	27	19	70.4
T8	27	15	55.6
T4/T8	27	7	25.9
B lymphocytes	24	14	58.3
CMI	34	25	73.5
Clinical status (from Table 39.4)	60	39	78.0

s and Method of Treatment, Vol IV, CRC-Press, 1997

**Transfer factor immunomodulation
clinical & scientific evidence from**

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Baylor College of Medicine
Brooke Army Medical Center
Columbia College of Physicians & Surgeons
DHHS - Center for Disease Control
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Kansas University Medical Center
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Allergy

American Journal of Diseases of Children

American Journal of Medicine

American Journal of Pathology

Annals of Allergy

Annals of Internal Medicine

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GLOSSARY

adhesion molecules - molecules that are involved in T helper-accessory cell, T helper-B cell, and T cytotoxic-target cell interactions; extracellular matrix proteins that attract leukocytes from the circulation.

adjuvant - a vehicle used to enhance antigenicity; e.g., a suspension of minerals (alum, aluminum hydroxide, or phosphate) on which antigen is adsorbed; or water-in-oil emulsion in which antigen solution is emulsified in mineral oil (Freund incomplete adjuvant), sometimes with the inclusion of killed mycobacteria (Freund's complete adjuvant) to further enhance antigenicity (inhibits degradation of antigen and/or causes influx of macrophages).

allergy - hypersensitivity caused by exposure to a particular antigen (allergen) resulting in a marked increase in reactivity to that antigen upon subsequent exposure, sometimes resulting in harmful immunologic consequences

antigen presenting cell - displays foreign antigen complexed with MHC on its surface. T-cells may recognize this complex using their T-cell receptor (TCR).

antioxidant - an agent that inhibits oxidation; any of numerous chemical substances, including certain natural body products and nutrients, that can neutralize the oxidant effect of free radicals and other substances.

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GLOSSARY

B lymphocyte - an immunologically important lymphocyte that is not thymus-dependent, is of short life, and resembles the bursa-derived lymphocyte of birds in that it is responsible for the production of immunoglobulins. It does not play a direct role in cell-mediated immunity.

basophil - a cell with granules that stain specifically with basic dyes, a phagocytic leukocyte of the blood characterized by numerous basophilic granules containing heparin and histamine and leukotrienes; except for its segmented nucleus, it is morphologically and physiologically similar to the mast cell though they originate from different stem cells in the bone marrow

cell-mediated immunity (CMI), cellular immunity - immune responses that are initiated by an antigen-presenting cell interacting with and mediated by T lymphocytes (e.g., graft rejection, delayed-type hypersensitivity).

chemokine - are a family of small cytokines, or proteins secreted by cells. Proteins are classified as chemokines according to shared structural characteristics such as small size. They induce directed chemotaxis in nearby responsive cells; they are chemotactic cytokines. Some are pro-inflammatory and can be induced during an immune response to promote cells of the immune system to a site of infection, while others are homeostatic and are involved in controlling the migration of cells during normal processes of tissue maintenance or development.

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GLOSSARY

concanavalin A - a phytomitogen, extracted from the jack bean (*Canavalia ensiformis*) that agglutinates the blood of mammals and reacts with glucosans; like other phytohemagglutinins, conA stimulates T lymphocytes more vigorously than it does B lymphocytes

corticotropin releasing hormone - CRH is secreted by the paraventricular nucleus (PVN) of the hypothalamus in response to stress. In addition to being produced in the hypothalamus, CRH is also synthesized in peripheral tissues, such as T lymphocytes, and is highly expressed in the placenta.

cortisol - a steroid hormone secreted by the adrenal cortex; an antiinflammatory agent.

cytokine - any of numerous hormonelike, low-molecular-weight proteins, secreted by various cell types, that regulate the intensity and duration of immune response and mediate cell-cell communication. (ie. chemokines, interleukin, lymphokine, & interferon)

cytotoxic T cells - destroy virally infected cells and tumor cells, and are also implicated in transplant rejection. These cells are also known as CD8+ T cells (associated with MHC class I), since they express the CD8 glycoprotein at their surface.

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GLOSSARY

delayed hypersensitivity - a cell-mediated response that occurs in immune individuals peaking at 24–48 hours after challenge with the same antigen used in an initial challenge. The interaction of T-helper 1 lymphocytes with MHC class II positive antigen-presenting cells initiates the response. This interaction induces the T helper 1 and macrophages at the site to secrete cytokines, which are the major players in the reaction. Called tuberculin-type hypersensitivity.

dendritic cell - of neural crest origin with extensive processes; they develop melanin early

eosinophil - these leukocytes are motile phagocytes with distinctive antiparasitic functions.

erythrocyte - a mature red blood cell

gamma-delta T cells represent a small subset of T cells that possess a distinct TCR on their surface. The antigenic molecules that activate gamma-delta T cells are still widely unknown. However, gamma-delta T cells are not MHC restricted and seem to be able to recognize whole proteins rather than requiring peptides to be presented by MHC molecules on antigen presenting cells.

genotype - 1) the genetic constitution of an individual. 2) gene combination at one specific locus or any specified combination of loci.

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GLOSSARY

Hashimoto's thyroiditis - diffuse infiltration of the thyroid gland with lymphocytes, resulting in diffuse goiter, progressive destruction of the parenchyma and hypothyroidism. * can be associated with hypothyroid, euthyroid and/or hyperthyroid states over time

helper T cells - (effector T cells or Th cells) are the "middlemen" of the adaptive immune system. Once activated, they divide rapidly and secrete small proteins called cytokines that regulate or "help" the immune response. Depending on the cytokine signals received, these cells differentiate into Th1, Th2, Th3, Th17, or one of other subsets, which secrete different cytokines.

hyperthyroidism - secretion of thyroid hormone is usually increased and is no longer under regulatory control of hypothalamic-pituitary centers; characterized by a hypermetabolic state, usually with weight loss, tremulousness, elevated plasma levels of thyroxin and/or triiodothyronine, and sometimes exophthalmos; may progress to severe weakness, wasting, hyperpyrexia, and other manifestations of thyroid storm; often associated with exophthalmos (Graves disease).

hypothalamus - links the nervous system to the endocrine system via the pituitary gland responsible for certain metabolic processes and other activities of the Autonomic Nervous System.

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GLOSSARY

hypothyroidism - diminished production of thyroid hormone, leading to clinical signs of thyroid insufficiency, including low metabolic rate, tendency to weight gain, somnolence & sometimes myxedema

immune complex - antigen combined with specific antibody, to which complement may also be fixed, and which may precipitate or remain in solution and is frequently associated with autoimmune disease

immune mediated inflammatory disease - In immunology, the condition in which one's own tissues are subject to deleterious effects of the immune system, as in autoallergy and in autoimmune disease; specific humoral or cell-mediated immune response against the body's own tissues. (autoimmune disease, autoallergy)

immunoglobulin (Ig) - one of a class of structurally related proteins. Antibodies are Ig's, and all Ig's probably function as antibodies. However, Ig refers not only to the usual antibodies, but also to a great number of pathological proteins.

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GLOSSARY

immunotherapy - originally, therapeutic administration of serum or immune globulin containing preformed antibodies produced by another individual; currently, immunotherapy includes nonspecific systemic stimulation, adjuvants, active specific immunotherapy, and adoptive immunotherapy. New forms of immunotherapy include the use of monoclonal antibodies

interferon - a class of small protein and glycoprotein cytokines produced by T cells, fibroblasts, and other cells in response to viral infection and other biological and synthetic stimuli. Interferons bind to specific receptors on cell membranes; their effects include inducing enzymes, suppressing cell proliferation, inhibiting viral proliferation, enhancing the phagocytic activity of macrophages, and augmenting the cytotoxic activity of T lymphocytes. Interferons are divided into five major classes (alpha, beta, gamma, tau, and omega) and several subclasses on the basis of physicochemical properties, cells of origin, mode of induction, and antibody reactions.

interleukin (IL) - group of multifunctional cytokines once their amino acid structure is known. They are synthesized by lymphocytes, monocytes, macrophages, and certain other cells.

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GLOSSARY

interleukin-1 (IL-1) - a cytokine, derived primarily from mononuclear phagocytes, which enhances the proliferation of T helper cells and growth and differentiation of B cells. When secreted in larger quantities it is a mediator of inflammation, entering the bloodstream and causing fever, inducing synthesis of acute phase proteins, and initiating metabolic wasting.

interleukin-2 (IL-2) A cytokine derived from T helper lymphocytes that causes proliferation of T lymphocytes and activated B lymphocytes.

interleukin-3 (IL-3) A cytokine derived from activated CD4+ lymphocytes, fibroblasts, and endothelial cells that increases production of monocytes. It acts in hematopoiesis by controlling production and differentiation of granulocytes. Syn: multicolonystimulating factor

interleukin-4 (IL-4) - a cytokine derived from T4 lymphocytes that causes differentiation of B lymphocytes. Promotes Ig class switch. It stimulates DNA biosynthesis. (B cell differentiating factor)

interleukin-5 (IL-5) - a cytokine derived from T lymphocytes that causes activation of B lymphocytes and differentiation of eosinophils.

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GLOSSARY

interleukin-6 (IL-6) - a cytokine derived from macrophages and endothelial cells that increases synthesis and secretion of immunoglobulins by B lymphocytes; also induces acute phase proteins. In hepatocytes, it induces acute-phase reactants.

interleukin-7 (IL-7) A cytokine derived from bone marrow cells that causes proliferation of B and T lymphocytes.

interleukin-8 (IL-8) A cytokine (chemokine) derived from endothelial cells, fibroblasts, keratinocytes, macrophages, and monocytes which causes chemotaxis of neutrophils and T-cell lymphocytes. Syn: monocyte-derived neutrophil chemotactic factor, neutrophil-activating factor, anionic neutrophil-activating peptide, neutrophil chemotactant factor

interleukin-9 (IL-9) A cytokine derived from T cells that causes IL-2/IL-4-independent growth and proliferation of T cells

interleukin-10 (IL-10) - a cytokine derived from helper T-cell lymphocytes (TH2) that inhibits -interferon (IFN) and IL-2 secretion by T cell lymphocytes (TH1) and inhibits mononuclear cell inflammation.

interleukin-11 (IL-11) A cytokine and growth factor derived from bone marrow stromal cells (endothelial cells, macrophages, and preadipocytes) that stimulates increased plasma concentrations of acute phase proteins and is a growth factor with multiple hematopoietic effects.

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GLOSSARY

interleukin-12 (IL-12) - a cytokine derived from B lymphocytes and macrophages that induces -interferon (IFN) gene expression and IL-2 in T lymphocytes and NK cells and down regulates Th2 cytokines.

interleukin-13 (IL-13) - a cytokine derived from helper T cell lymphocytes that inhibits mononuclear cell inflammation and is considered a modulator or B cell responses.

interleukin-14 (IL-14) A cytokine derived from T cells that stimulates B cell proliferation and inhibits Ig secretion.

interleukin-15 (IL-15) A cytokine derived from T cells which stimulates T cell proliferation and NK cell activation.

interleukin-16 (IL-16) A cytokine made by T cells that is a potent chemotactant for CD4+ T cells.

interleukin-17 (IL-17) - a proinflammatory cytokine made by T cells

interleukin-18 (IL-18) A cytokine made by macrophages; a potent inducer of interferon- by T cells and NK cells.

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GLOSSARY

intravenous gammaglobulin (IGIV) - patients with primary immunodeficiency diseases have been treated with intravenous gammaglobulin (IGIV) for over 20 years. Gamma globulins were first introduced as a therapeutic modality in 1952 by Robert A. Good, who injected gamma globulins by the intramuscular (IM) route to treat patients with X-linked agammaglobulinemia. Subsequently, the clinical indications for gamma globulins therapy expanded from patients with Bruton's disease and other primary immune deficiency disorders to include a variety of autoimmune and inflammatory diseases. Availability of IGIV product has been of particular concern to the clinical immunologists who take care of patients with primary immune deficiency disorders since there are no alternative therapies for these patients. Many of our patients have received IV gammaglobulin, particularly before the first Gulf War when it was generally available. It was not effective in our patients with combined Th1 - Th2 immunoregulatory defect, who did not have a concomitant immune defect that responds to IVIG.

macrophage - any mononuclear, actively phagocytic cell arising from monocytic stem cells in the bone marrow & are involved in both the production of antibodies and in cell-mediated immune responses, participate in presenting antigens to lymphocytes, and secrete a variety of immunoregulatory molecules.

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GLOSSARY

memory T cells - are a subset of antigen-specific T cells that persist long-term after an infection has resolved. They quickly expand to large numbers of effector T cells upon re-exposure to their cognate antigen, thus providing the immune system with "memory" against past infections. Memory cells may be either CD4+ or CD8+.

mitogen - a substance frequently derived from plants that stimulates mitosis (cell division) and lymphocyte transformation; includes not only lectins such as phytohemagglutinins and concanavalin A, but also substances from streptococci (associated with streptolysin S) and from strains of -toxin-producing staphylococci.

monocyte - A relatively large mononuclear leukocyte (16–22 m in diameter), that normally constitutes 3–7% of the leukocytes of the circulating blood, and is normally found in lymph nodes, spleen, bone marrow, and loose connective tissue.

mucocutaneous candidiasis - infection of skin &/or mucous membranes caused by, *Candida*, especially *C. albicans*, resulting from abnormal cell mediated immunity (Th1 defect), debilitation (as in immunosuppression and AIDS), physiologic change, prolonged administration of antibiotics, and iatrogenic and barrier breakage

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GLOSSARY

natural killer T cells (NKT cells) are a special kind of lymphocyte that bridges the adaptive immune system with the innate immune system. Unlike conventional T cells that recognize peptide antigen presented by major histocompatibility complex (MHC) molecules, NKT cells recognize glycolipid antigen presented by a molecule called CD1d. Once activated, these cells can perform functions ascribed to both Th and Tc cells (i.e., cytokine production and release of cytolytic/cell killing molecules).

neutrophil - a mature white blood cell in the granulocytic series, formed by myelopoietic tissue of the bone marrow (sometimes also in extramedullary sites), and released into the circulating blood, where they normally represent 54–65% of the total number of leukocytes.

pathophysiology - derangement of function seen in disease; alteration in function as distinguished from structural defects

phenotype - the observable characteristics, at the physical, morphologic, or biochemical level, of an individual, as determined by the genotype and environment

phytohemagglutinins - a phytomitogen from plants that agglutinates red blood cells. The term is commonly used specifically to refer to the lectin obtained from the red kidney bean (*Phaseolus vulgaris*), which is also a mitogen that stimulates T lymphocytes more vigorously than B lymphocytes

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GLOSSARY

pituitary - releases the neurosecretory hormones oxytocin and antidiuretic hormone; secrete somatotropins, prolactin, thyroid-stimulating hormone, gonadotropins, adrenal corticotropin, etc.

platelet - a fragment of a megakaryocyte that is shed in the marrow sinus and subsequently found in the peripheral blood, where it functions in clotting and contains no hemoglobin.

polymorphonuclear leukocyte - contains varying shapes of the nucleus, which is usually lobed into three segments. In common parlance, the term polymorphonuclear leukocyte often refers specifically to neutrophil granulocytes,[2] the most abundant of the granulocytes. Granulocytes or PMN are released from the bone marrow by the regulatory complement proteins

regulatory T cells (Treg cells) (formerly known as suppressor T cells) are crucial for the maintenance of immunological tolerance. Their major role is to shut down T cell-mediated immunity toward the end of an immune reaction and to suppress auto-reactive T cells that escaped the process of negative selection in the thymus. Two major classes of CD4+ regulatory T cells have been described, including the naturally occurring Treg cells and the adaptive Treg cells.

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GLOSSARY

supernatants - clear fluid that, after the settling out of an insoluble liquid or solid by the action of normal gravity or of centrifugal force, takes up the upper portion of the contents of a vessel.

T cell (includes Th1 & Th2) a thymocyte-derived lymphocyte of immunologic importance that is long-lived (months to years) and is responsible for cell-mediated immunity. T lymphocytes form rosettes with sheep erythrocytes and, in the presence of transforming agents (mitogens), differentiate and divide. These cells have characteristic CD3 surface markers and may be further divided into subsets according to function, such as helper, cytotoxic, etc.

toll-like receptors - Toll-like receptors (TLRs) are a class of single membrane-spanning non-catalytic receptors that recognize structurally conserved molecules derived from microbes once they have breached physical barriers such as the skin or intestinal tract mucosa, and activate immune cell responses. They are believed to play a key role in the innate immune system.

toxicity - is the degree to which a substance is able to damage an exposed organism. Toxicity can refer to the effect on a whole organism or the effect on a substructure of the organism, such as a cell (cytotoxicity) or an organ (organotoxicity) such as the liver (hepatotoxicity). A central concept of toxicology is that effects are dose-dependent.

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GLOSSARY

transfer factor - a dialyzable extract that is obtained from the leukocytes of a person with a delayed-type sensitivity and that, following injection into the skin of a nonsensitive person, transfers the specific sensitivity to the recipient

tumor necrosis factors are a group of cytokines family that can cause apoptosis, programmed cell death

Wiskott Aldrich syndrome - an immunodeficiency disorder occurring in male children, characterized by thrombocytopenia, eczema, melena, and susceptibility to recurrent bacterial infections; death occurs from severe hemorrhage or overwhelming infection; X-linked recessive inheritance, caused by mutation in the Wiskott-Aldrich syndrome protein (WASP) on chromosome Xp.

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I clearly remember standing in line with 150 other graduates shaking Columbia Physician and Surgeon Dean Ann Peterson, M.D.'s hand as I accepted my diploma. And even then we could not let go of the compulsivity required to stay on the top of our game as newly minted physicians. Everyone was discussing what medical journals we should subscribe to with our first paycheck as interns. We were all looking forward to the future, however bittersweet medicine's future always is. In immunology, joy came with stem cell therapies. . .and the tragedy of HIV. I close with what I completely missed on graduation day. Sometimes you really need to look backwards, not forwards. A four billion dollar medical lobbying industry depends on the old being replaced with something shiny and new. But in the case of our patients with severe symptoms from this combined Th1 - Th2 immunoregulatory defect, there is nothing new. For them transfer factor is LIFE.

I declare on this the 25th day of September in the city of Laguna Hills, CA under penalty of perjury that this information is true and correct to the best of my knowledge.

s/ Dorothy Calabrese, M.D.

L - PAUL MESSE R

I am a Medicare Part B beneficiary in good standing. I have longstanding extensive allergies, allergic hypersensitivity to chemicals, and abnormal cell-mediated immunity and have required transfer factor immunomodulatory therapy as a medically necessary treatment. My relevant diagnoses include:

Extensive allergies IgE 541 IU (nl 0-180)

Allergic rhinosinusitis

Multiple chemical sensitivity

Immune dysregulation

Elevated %NK cell (CD3-/NKH1+) 13%

(nl. 2.7-11.3)

Elevated total NK cells (CD3-/NKH1+)

325 mm³ (nl. <38- 260)

C-4 46 mg/dl (nl. 16-45)

CH50 98 (nl <60 CAE)

Phytohemagglutinin 5,340 cpm (control
19,511)

Concavalin A 13,579 cpm (control 32,012)

Asthma

Irritable bowel syndrome

Urticaria

Medication sensitivities: many medications

My parents both had allergies as well as two of my three sisters. However, at thirteen my allergies became overwhelming, with the onset of asthma and the need to curtail activities that I had once taken for granted. In my teens I was

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treated by top Board-certified allergists at the Portland Allergy Clinic with antigen immunotherapy for several years. It became apparent then that my allergies were more complex as I did not respond to any of the treatments - neither immunotherapy or pharmaceuticals. So I had to rely on avoidance alone for many years.

I was then treated by a top Board certified allergist in Seattle, again with antigen immunotherapy and pharmaceuticals for an extended period of time with no results. When that didn't work I tried another top Board-certified allergist in Seattle. He repeated the same care with antigen immunotherapy and pharmaceuticals for an extended period of time, again with no results. In fact, the allergies and asthma only became more progressive.

Years later I knew I simply had to try to specialized allergy care again. I saw Board certified allergist Ronald Gehling, MD in San Clemente, CA, who was extremely thorough. He tested me with every antigen he had available. I tested positive to 70% of the numerous antigens he tested. Dr. Gehling treated me with antigen immunotherapy and pharmaceuticals for a long time. Again I was totally non-responsive.

I then saw Board certified allergist Steven Weinstein MD in Newport Beach, who is at UCI. Dr. Weinstein did the allergy testing and offered the same care I had received from the previous four allergists. I progressively became sensitive to chemicals for the first time.

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My asthma became debilitating on exposure to diesel exhaust particulate, certain colognes, certain perfumes, and so forth. My energy level precipitously dropped off and I became short of breath much of the time. My terrific longstanding internist, James Hawkins, M.D. of Laguna Hills referred me to multiple specialists, including an infectious disease specialist, pulmonologist and gastroenterologist. They could find no reason for the abrupt deterioration in my health from their specialty perspective.

I went to the Optimum Health Institute in San Diego for three weeks without any improvement. Then I was referred to Jay Goldstein, M.D., a neuro-immunologist, in Anaheim, who specialized in chronic fatigue syndrome. He did diagnose high ferritin, which was formally diagnosed as hemochromatosis when the genetic test was available. Dr. Goldstein explained hemochromatosis was not the cause of my deteriorating health problem. He treated me with a wide range of pharmaceuticals, none of which were effective, and many of which I was intolerant to. I then saw James Ziegenbein, MD at UCI and the Center for Special Immunology because he was specialized in infectious disease and the immune part that was destroying my health and ability to perform activities of daily living. He treated me with IV gamma globulin infusions (\$1700 an infusion) for eight months. I was totally non-

responsive and stopped the treatment. A friend of mine, a United Airlines flight attendant with severe allergies, who was a patient of Dr. Calabrese's referred me to her. When I met with Dr. Calabrese she screened me very carefully. I immediately knew that she was approaching these longstanding health problems from a different vantage point than the eight allergists - immunologists that I had previously seen. Dr. Calabrese explained that she and her family had similarly been outliers due to a combination of the extensive allergies with less common immune problems. Dr. Calabrese took a long history and asked a lot of questions I had never been asked before. She explained the rationale of using custom made biologicals, which made sense after having had the standard allergy shots so many times with so many allergists. The immune work-up showed that I was a good candidate for the transfer factor immunomodulatory therapy. Frankly, Dr. Calabrese was the first doctor who made sense to me in how she chose the laboratory work-up, did the allergy testing with custom fresh-frozen preservative antigens looking for both acute and delayed responses, and could address the immune side with the transfer factor. She explained that I would know within 60-90 days if I was going to respond and if I did not, we would simply stop, unlike the previous allergists-immunologists who treated me well beyond the time that it was clear I was not responding.

During the testing I had the opportu-

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nity to meet many other of her patients and realized my good fortune in living in South County as many of these patients came from very long distances.

After six months, I experienced a tremendous shift in my health particularly with my asthma and energy level. I was able to walk and swim. I was no longer so homebound and started a social life again. I was even able to go to the beach and go in the ocean. I became so much more well than I had been in many years that I was able to visit my parents in Texas before they died. Dr. Calabrese had explained that most patients can stop the immunotherapy after 3 years and will do fine for a good ten years or even longer before they may need to receive immunotherapy again. At the three year mark, it was clear that I was doing well but I continued longer because the problems I had were so severe for so many decades. My third-party insurance always paid appropriately. I continued the antigen immunotherapy and transfer factor immunomodulatory therapy for a total of five years and did extremely well. Although Dr. Calabrese had told me to stop the care, she had explained at some point I may need immunotherapy again. So I thought I was cured. However, about one and a half years after stopping, it became clear that the effects of the antigen immunotherapy and transfer factor immunomodulatory therapy were gradually wearing off.

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Because Dr. Calabrese had diagnosed me with Hashimoto's thyroiditis, Dr. Hawkins recommended I see Alan Marcus MD, a Board-certified endocrinologist, at Saddleback Hospital in Laguna Hills. Dr. Marcus was confident that treating me endocrinologically would make all the difference. In addition to the thyroid I was already taking after seeing Dr. Calabrese, Dr. Marcus placed me on testosterone and steroids for over a year. My body weight increased by 50% and my health deteriorated terribly.

I then developed a heart arrhythmia, my asthma and shortness of breath returned, and my overall health scared me. My cardiologist tried heart medications to regulate the arrhythmia and I was extremely sensitive to all of them. At this time, I was now a Mecare patient. I knew it was time to see Dr. Calabrese again. She immediately told me to forget the cardiac medications. She explained that physics rather than chemicals was the better option with my history. So I had a defibrillator implanted, which I have now had since 1998 and has been lifesaving. Dr. Calabrese said she hardly recognized me and to stop seeing Dr. Alan Marcus, to stop the steroids, stop the testosterone and she changed my thyroid medication. I went through the allergy testing for foods, molds, pollens etc again to get current doses and restarted the transfer factor immunomodulatory therapy.

Dr. Calabrese has explained that about 10% of the patients in her practice need the

L - PAUL MESSE R

immunotherapy long term. However, I already knew based on all the allergy-immunology specialists that I had seen over so many decades that I was always the unusual patient in all their practices. So it did not surprise me, after the immunotherapy wore off that I needed it long term. It has been extremely difficult worrying about my Medicare benefits for this care being stopped for now five years. Professionally, I was a regional sales manager for Sunset Magazine and Kipplinger Publishing and understand the business model. As I explained to this Court on March 31, 2008, this care is well worth it and much less expensive than dealing with the incapacitating symptoms that I have when I do not receive this care. Although we are few in number, allergy-immune patients who are outliers in the same way that I am, need and deserve this specialized care. Dr. Bruce Quinn and his paid expert contend this care yields placebo results. It is totally inconsistent with my medical history that suddenly custom biologicals work when no other care ever worked.

On September 24, 2007, this Court dismissed my case: SACV06-1217 CJC(RNBx). I didn't want to admit that the stress of losing the case and potentially losing my care with Dr. Calabrese would ever have such a profound emotional effect on me. Shortly after hearing this news, I felt like I was going to pass out, shortness of breath, I started sweating, my heart

L - PAUL MESSER

went to 130 beats per minute and felt like I was going into complete cardiac arrest. I required 24 hour heart monitoring, nuclear stress testing, angiogram and a complete cardiac evaluation.

Stephen Ehrlich, MD, my cardiologist at Mission Hospital, said he had no idea what triggered the six days of cardiac instability except the stress. Furthermore, he underscored the fact that I am very different than his other cardiology patients with this same arrhythmia because of my allergic-immune problems.

Because my case SACV06-1217 CJC(RNBx) was dismissed based on sovereign immunity, I realize and the Court has written that the current motion on sovereign immunity in SACV07-1444 CJC(RNBx) is extremely critical for us to win because the alternative is another Ninth Circuit Appeal. I have every confidence in the US Court of Appeals but we really need timely justice. Justice delayed is justice denied. I know Dr. Ehrlich would advise me to give a written declaration rather than oral testimony at this time. However, if the court has any questions about this declaration, I would be happy to answer them on Tuesday, July 22, 2008 at the hearing.

I declare on this the 26th day of July 2008 in the city of Laguna Hills that this information is true and correct to the best of my knowledge under penalty of perjury.

/s/ Paul Messer

M - ALAN LEVIN, M.D., J.D.

TO THE HONORABLE RICHARD B. GOULD

**OFFICE OF MEDICARE HEARINGS AND
APPEALS**

**STATEMENT OF ALAN S. LEVIN, M.D.,
J.D.**

**ON TRANSFER FACTOR
IMMUNOMODULATORY THERAPY**

INTRODUCTION

Patients with undiagnosed immune mediated inflammatory disease (formerly known as autoimmune disease) and nascent malignancies often present with extensive allergies (including allergic hypersensitivity to chemicals) decades prior to the clinical presentation of their underlying disease.

In my forty-four plus years of medical practice, I can state that after an extensive medical evaluation of MCS patients, the underlying nascent disease can be identified in the overwhelming majority of these patients as their disease progresses.

In a small group of such patients the underlying cause of their allergic symptomatology eludes

discovery. For these patients specific and non-specific immunomodulatory treatment is warranted. Specific treatment involves hyposensitization with allergens against which the patient reacts in skin tests, often using preservative free antigens. The non-specific treatment involves IV gammaglobulin and transfer factor therapy.

IV gammaglobulin and transfer factor immunomodulatory therapy (dialyzable leukocyte extract) can be extremely safe and effective in relieving debilitating constitutional symptoms and organ specific symptoms, particularly in combination with preservative - free antigen immunotherapy in these patients.

I'm a Certified Diplomate of the American Board of Allergy and Immunology (1975-present), the American Board of Pathology-Clinical Pathology (1977-present) and am a founding member of the American College of Emergency Medicine. I served on the California Medical Board (Board of Medical Quality Assurance) Nov 1982 - Nov 1987 and Aug 1990 - Nov 1993. I was formerly an Adjunct Associate Professor of Dermatology at California San Francisco Hospitals.

I'm a Daubert-qualified expert on the use of these therapies in this patient group. I've done research and published peer-reviewed articles in this field. In my allergy-immunology medical practice in San Francisco, I treated patients with extensive allergies and abnormal cell-

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mediated immunity with preservative-free antigen immunotherapy and transfer factor immunomodulatory therapy for many decades and the therapy was both safe and effective.

Douglas H. Sandberg, M.D. is Emeritus Professor of Pediatrics at the University of Miami Medical Center, Chief of Gastroenterology and Nutrition and the Allergy and Nutrition Unit for more than four decades. Based on our collective clinical experience on two coasts with these patients, Dr. Sandberg and I both state that the transfer factor immunomodulatory therapy and preservative-free antigen immunotherapy are safe and effective when self-administered in this patient group. [See Sandberg declaration]

TRANSFER FACTOR IMMUNOMODULATORY THERAPY

H. Sherwood Lawrence, Professor of Medicine, Head of the Infectious Diseases and Immunology Division, Co-Director of Medical Services, New York University Medical Center pioneered the first fifty years of transfer factor work. In 1954, he reported that it was possible to transfer delayed hypersensitivity from sensitized donors to insensitive recipients with disrupted leukocytes.

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While working on the passive transfer of cellular immunity by intact lymphocytes, Dr. Lawrence observed that passive transfer could be induced using nonviable lymphocytes. This led to discovering that leukocyte homogenates could transfer cellular immunity. Lawrence characterized the active factor in the leukocyte homogenate and discovered that activity was lost after dialysis. This led to examination of the dialysis fluid outside of the bag (dialysate) for the lost activity. After concentrating the diffusate, Dr. Lawrence not only found that he could passively transfer the skin-test reactivity concomitant with donor specificities, but also that the activity of the extract was intensified. Lawrence reported that the active component in the cell extracts, dialyzable leukocyte extract (DLE) had a molecular weight of 10,000 daltons or less. [1]

It wasn't until the early seventies, when our group at University of California at San Francisco reported the therapeutic use of transfer factor. [2]

CHARACTERISTICS OF TRANSFER FACTORS:

Transfer factors are proteins that transfer the ability to express cell-mediated immunity from immune donors to non-immune recipient.[3]

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1. It has been demonstrated that they activate the effect or mechanisms of the cell-mediated immune system, and that they have no significant effects on the B cell-mediated immune function. [4] [5]
2. The most consistent in vitro effect resulting from administration of transfer factor has been antigen-specific production of macrophage migration inhibitory factor or leukocyte migration inhibitory factor by the recipients' peripheral blood mononuclear cells. [2] [6] [7]
3. Studies also suggest increased lymphocyte proliferation demonstrated by the thymidine-incorporation assay and increased activity of cytotoxic T cells. [8][9] [10]
4. Studies have shown that in-vivo administration of transfer factors endows the recipients' spleen cells with the property of responding to the corresponding antigen in vitro by secreting gamma-interferon, but not production of interleukin IL-2, IL-4 and IL-10. [3]
5. The small molecular weights of transfer factors (molecular mass E 5000 Daltons) are quite different from immunoglobulins, major histocompatibility complex (MHC) molecules and T-lymphocyte receptors. Like immunoglobulins, transfer factors bind to intact antigen molecules, but reduction and alkylation of transfer factors does not dissociate them into heavy chains and light chains. T-lymphocyte receptors do not bind intact antigen molecules as transfer factors do, yet the immune responses

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that are "transferred" to recipients of transfer factors are mediated by T lymphocytes. It is possible that transfer factors operate through an unique mechanism of antigen presentation and T-cell activation. [11] [12] [13]

6. Alvarez-Thull and Kirkpatrick describe a conserved or constant region that may serve as a binding site for cells that are the primary targets of transfer factors. Different regions of transfer factor molecules appear to have variable amino acid sequences that determine the epitope specificity of individual transfer factors.

A novel amino acid sequence, LLYAQDL/VEDN, was identified in each of seven transfer factor preparations. The peptides LLYAQDLEDN, LLYAQDVENDN,

LLYAQDLED, LYAQDLEDN, YAQDLEDN, AQDLEDN, and LAYAQKLEAN were synthesized with an ABI 431A peptide synthesizer (Perkin Elmer :ABI) by the Molecular Resources Laboratory of the National Jewish Medical and Research Center, Denver. These peptides do not transfer expression of delayed-type hypersensitivity to recipients. This indicates that they are not sufficient for expression of the specificity or immunological properties of native transfer factors.

However, administration of the peptides to recipients of native transfer factors blocked expression of delayed-type hypersensitivity by the recipients. The peptides were not immunosuppressive. These findings are consistent in that the peptides may represent the portion of

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transfer factors that binds to the target cells for transfer factors. [12]

7. Ongoing work by Charles H. Kirkpatrick, Professor of Medicine and Director, Adult Immunodeficiency Program at the University of Colorado Health Center – National Jewish Medical and Research Center has shown that activation of the T helper type 1 cell (Th1) is an immunologic mechanism that is activated in transfer-factor recipients. Specifically, the cytokine profiles of recipients of a Herpes simplex virus type-I (HSV-1) specific TF were determined. Cytokine profiles in transfer factor recipients were consistent with activation of a Th1 subset of helper T cells. Cytokines are known to be pluripotent, in that each of these compounds can activate specific behavior in some cell types and inhibit other behavior in other cell types. [3][11]

EFFECTS OF TRANSFER FACTORS VARY FROM INDIVIDUAL TO INDIVIDUAL:

1. Burger showed that dialysates from leukocytes of insensitive donors wouldn't sensitize recipients to keyhole-limpet hemocyanin (KLH), but identical dialysates from the same donors after sensitization with KLH regularly sensitized recipients. [14]

2. Petersen used a mouse model to provide additional evidence that the immunological effects of transfer factor are antigen specific. [15]

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3. Kirkpatrick showed it is possible to transfer delayed-type hypersensitivity to synthetic antigens that have no known natural equivalent with DLE. [16]

4. Transfer factor has been shown to restore cell mediated immunity to immunodeficient patients with opportunistic infections.

a . controlled clinical trial, Steele et al. gave placebo or transfer factor from a zoster-immune donor to a group of children with leukemia. Exposures to chicken pox were monitored. Of 16 exposed children in the placebo group, 13 developed chickenpox, only 1 of the 15 exposed children in the transfer-factor treated group developed lesions. [17]

b. Dwyer had equally impressive results in patients with persistent or recurrent infections caused by herpes simplex. When the patients were treated with transfer-factor-containing leukocyte dialysates from donors with cell-mediated immunity to herpes simplex, the frequency of the infections were markedly reduced. In fact, 6 of 11 patients were freed of herpes-virus infections, and 3 additional patients had greater than 80% reductions in the frequency of infection.[18]

c. Transfer factor has also been shown to provide clinical benefit and restored immune competence to some patients with chronic mucocutaneous candidiasis in many studies and in Polyglandular Autoimmune Syndrome Type I. [19]

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5. Transfer factor has been shown in many studies to be efficacious in a number of immunodeficiency disorders that are associated with persistent or recurrent infections with viruses, fungi, mycobacteria and intestinal parasites. 6. Transfer factor has prolonged survival and disease-free intervals of patients with osteogenic sarcoma and other malignancies. [8] [21][22]

COMBINED IMMUNOTHERAPIES IS COMMON SENSE

Refractory patients with extensive allergies, including allergic hypersensitivity to chemicals, and delayed type hypersensitivity must be treated with respect. Many are very bilitated and ill. The preservative-free antigen immunotherapy and transfer factor immunomodulatory therapy are safe, effective and of the immunopathologies.

Respectfully submitted on January 7, 2008;



Alan S. Levin, M.D., J.D.

M - ALAN LEVIN, M.D., J.D.

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N - DOUGLAS SANDBERG, M.D.

**DECLARATION OF
DOUGLAS H. SANDBERG, M.D.**

Douglas H. Sandberg, M.D.
2901 Bayshore Drive 4A
Miami, FL 33133-6001

I am an Emeritus Professor of Pediatrics at the University of Miami Medical Center, Jackson Memorial Hospital, where I practiced for more than four decades.

I was Chief of Gastroenterology and Nutrition including the Allergy and Nutrition Unit.

I was the attending physician for many years for Nicole Marmon Friedenberg, starting in 1975, and Andrew Calabrese, starting in 1986. Both required long term immunotherapy from infancy. Both patients' parents were able to safely administer their immunotherapy, as were my other allergy-immunology patients.

When I retired in 1997-1998, I referred Ms. Friedenberg to Dorothy Calabrese, M.D. in Laguna Hills, CA for ongoing care. Since that time, Nicole has received both allergy-immunotherapy and transfer factor immunomodulatory therapy from Dr. Calabrese, which she self-administers at home. Medicare should not preclude reimbursement for these safe and ef

fective immunotherapies because they are self-administered.

I declare on this 15 day of December 2007, In the city of Miami, Florida that this information is true and correct to the best of my knowledge.

A handwritten signature in black ink, appearing to read "Douglas H. Sandberg, M.D." The signature is fluid and cursive, with "Douglas H." on top and "Sandberg, M.D." below it.

Douglas H. Sandberg, M.D.

N - DOUGLAS SANDBERG, M.D.

Nicole Marmon Friedenberg worked as an attorney for:

1) O'Melveny & Myers LLP
Embaracadero Center West
275 Battery St. 24th Floor
San Francisco, CA 94111-3305
for two years

2) Then she clerked for a Federal District Judge
in South Florida for two years.

3) She now can be reached at:
Winston & Strawn LLP
101 California Street
Suite 3900
San Francisco, CA 94111
(415) 591-1581

N - DOUGLAS SANDBERG, M.D.

NICOLE MARMON, J.D.

November 9, 2003
Arthur Lurvey MD
Carrier Medical Director
National Heritage Insurance Company
1055 West 7th Street, Fifth Floor
Los Angeles, CA 90017
Dear Dr. Lurvey:

I am outraged at Medicare's denial of all coverage for immunotherapy treatment administered by Dr. Dorothy Calabrese. I am shocked and appalled that Medicare would deny treatment so fundamental to human life, in direct violation of court orders to the contrary.

As an infant, I was critically ill with severe food and environmental allergies. Initially, however, each doctor to examine me could not form a diagnosis. I almost died.

As a last resort, the hospital in which I was born sought the expertise of Dr. Douglas Sandberg, Professor of Pediatrics, Chairman of Gastroenterology and Nutrition, and Head of the Environmental Allergy Unit at the University of Miami, Jackson Memorial Medical Center.

N - DOUGLAS SANDBERG, M.D.

Dr. Sandberg discovered that I was allergic to all foods, most inhalants, and most medications. Unfortunately, I had inherited this illness from my father.

Dr. Sandberg stabilized me on immunotherapy injections, and I was finally able to leave the hospital. He was the ONLY doctor who was able to help me and he spent more than twenty years making sure that I would grow up to be a happy, healthy adult. He saved my life.

Because of the severe nature of my illness, I required Dr. Sandberg's immunotherapy treatment into adulthood, especially when I moved by myself from South Florida to California to attend Stanford University. I could not eat, drink, or breathe without the daily injections I received. If I were to stop my immunotherapy treatment, the symptoms from my basic, genetic illness would return.

The most dreaded day of my young life came when Dr. Sandberg retired. With his retirement went his treatment. I feared for my life. I knew that if I did not continue to receive immunotherapy treatment, I would not be able to live normally, if at all.

N - DOUGLAS SANDBERG, M.D.

Thankfully, Dr. Sandberg referred me to Dr. Dorothy Calabrese. He knew her work firsthand. She was the only specialist in this region who used the same type of custom immunotherapy that I required.

I have been a patient of Dr. Dorothy Calabrese for approximately seven years. In order to continue to live the life that I have built for myself in California, I require ongoing biweekly injections of transfer factor and allergy immunotherapy.

The only reason that I was able to graduate from Stanford University (B.A., 1997) and, most recently, from the University of California Hastings College of the Law (J.D. cum laude, 2003) was because Dr. Calabrese kept me alive with transfer factor and custom, preservative-free allergy immunotherapy.

Medicare's decision directly affects the rest of my life. If Medicare denies coverage for immunotherapy treatment, Dr. Calabrese will be put out of business. This is unacceptable. You see, in two weeks, I find out whether or not I passed the California Bar Exam. And, last night, I became engaged to a wonderful man, with whom I intend to raise a family.

N - DOUGLAS SANDBERG, M.D.

For twenty eight years, I have struggled for the kind of happiness I now have, and I will not have that threatened by a single Medicare analyst who has unilaterally decided to deny coverage for this treatment because she believes it is "strange" that Dr. Calabrese has dedicated herself to treating this orphan illness. It is not strange. It is a miracle.

Moreover, as a soon-to-be attorney, I am in disbelief that this agency would stand in direct defiance of federal court decisions, holding that transfer factor immunomodulatory reagent and preservative free allergy extracts are medically necessary and covered under Social Security Title XVIII/Medicare.

I beseech you to do the right thing and reinstate coverage for this treatment. Should you wish to discuss this matter further, please do not hesitate contact me. Thank you for your time.

Sincerely,



Nicole Marnon, J.D.

O - CLINICAL & SCIENTIFIC

Transfer Factor Immunomodulatory Therapy
Medical Textbooks- peer reviewed
(Alphabetical by First Author)

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Charles Kirkpatrick MD, Ch 11 - Delayed Hypersensitivity
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Alan Levin MD, J.D. Chapter 60: Transfer Factor and Allergies
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Transfer Factor Immunomodulatory Therapy

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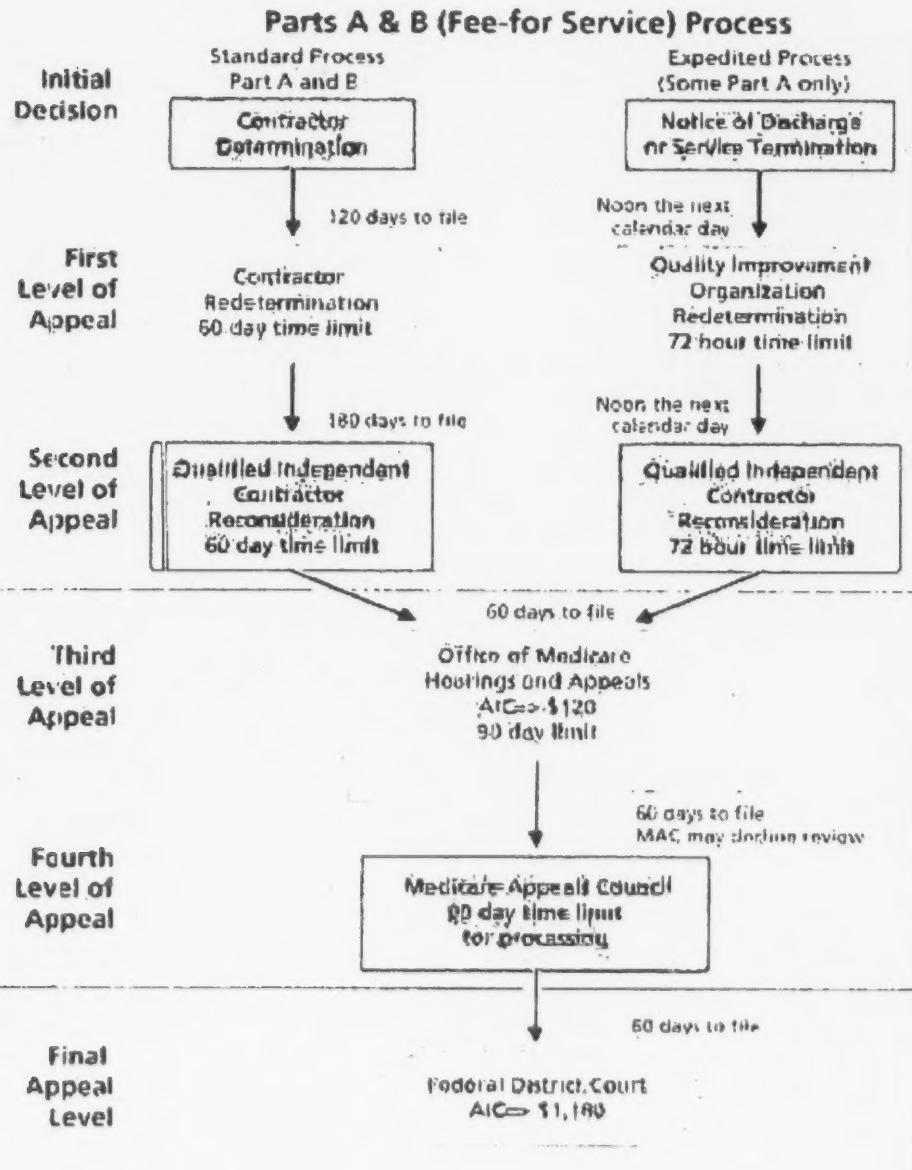
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P - APPEALS TIMELINE



Q - YALE LAB DIRECTOR

Yale University

*Department of Epidemiology
and Public Health
School of Medicine
60 College Street
P.O. Box 20804
New Haven, Connecticut 06530-0044*

DECLARATION

**Scott Matthews, M.P.H.
Yale University Medical Center Faculty
Dept of Epidemiology and Public Health**

On November 20, 2003, I attended a meeting with the NHIC physician consultants at 1055 West Seventh Street, Fifth Floor, Los Angeles, California. Neither medical consultant had any clinical experience with transfer fractor or preservative-free antigen immunotherapy.

The NHIC physician consultants acknowledged that between January 25 and November 20, 2003 they had no effort to read the US Federal Court of Appeals decisions of Judges Stanley Sadur and Arthur Cahn.

They similarly acknowledged they had never read a single article, review, study, case summary, or book in the published medical literature with respect to the use of transfer factor or preservative-free antigen immunotherapy.

Q - YALE LAB DIRECTOR

These citations were provided to them in correspondence dated January 25, 2003.

The full time medical consultant dismissed transfer factor, saying, "If [transfer factor] is so terrific, why isn't everyone using it?"

The part-time NHIC medical consultant stood, bent over and pointed at us:

"It doesn't matter whether [transfer factor] works or not. You need to do what everybody else does –what you need to do is to get a group of doctors and put together a PAC [Political Action Group]. Other doctors got together and fought. That's what you need to do."

I declare, under penalty of perjury, that the foregoing is true and correct to the best of my knowledge in Laguna Hills, California on this day November 21, 2003.



Scott Matthews

R - DR. BRUCE QUINN, CMD

Emerging Enterprise
Center



National Heritage Insurance Company

**What Early Stage Life Sciences Companies Need To
Know About Medicare Coverage and Reimbursement**

Wednesday, September 13, 2006

Bruce Quinn, MD, MBA
Medical Director
National Heritage Insurance Company (NHIC)

Overview

- Medicare is administratively complex
- How is "reasonable and necessary" explained?
- Major features of the LCD process
 - Novel molecular tests confront Medicare and you with new hurdles
 - Case Study
 - Final thoughts: FDA versus Medicare; Coding and pricing

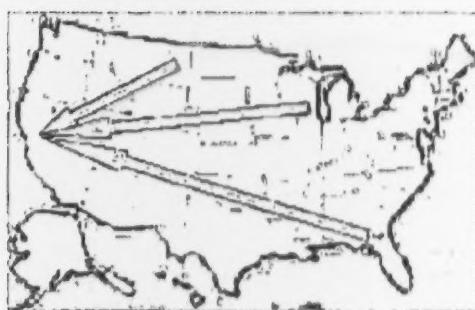
Bruce Quinn, MD, MBA

Emergency Physician
Critic



R - DR. BRUCE QUINN, CMD

Hurdles for Contracts (2,3)



- LCL
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[1] <http://www.fda.gov/bbs/topics/iby/371003/37101403.html>

See also:

http://www.dgsjpolis.vg/polity/issue.php?act=one&detail&issuebrief_id=10

<http://www.issues.org/22.3/iv/3.htm> (Jain & Hudon 2006)
Managing Science Governance/index.htm?Russell+Reviews+Detail&Heating

Bruce Quinn,
Emerging Enterprise
Center at TULLY HONG LLP

R - DR. BRUCE QUINN, CMD

•actor & Genomic Health (2,3,4)

LCD/NCD. All specimens in US sent to California, LCD = NCD.

FDA/CLIA. Changing world for FDA versus CLIA regulation

- FDA proposed new draft rules on September 5 (*)
- So far these have been "home brew" tests not marketed across state lines
- Congress, watchdogs groups see "regulatory gap"

Administrative Law Judge.
Firm can concentrate bundle of cases (e.g. "\$1M") on one ALJ.

1_4-10

Healthcare 03/98

Quinn, MD, MBA



S - PATIENT OF DR. KANTER

**Beverly Patricia Meyer
10962 East Escolera Circle
Camarillo, CA 93012**

I was patient under the care of Dr. Lewis J. Kanter, M.D. during 1996. I saw him in all three of his offices: Camarillo, Simi Valley, and Thousand Oaks. Dr. Lewis J. Kanter is now testifying as an allergy-immunology expert against the medical necessity of transfer factor immunomodulatory therapy for any medical condition.

Dr. Kanter tested me for allergies and prescribed allergy medication and prepared allergy immunotherapy serum for me. However, I was so sick that Dr. Kanter agreed that I wasn't well enough to do the allergy immunotherapy.

My condition did not improve. I saw two more Board-certified allergist-immunologists.

My fourth allergist-immunologist was Dr. Dorothy Calabrese in Laguna Hills, who I first saw on May 18, 2006.

I want to share with you some of the incredible changes I've experienced under the care of Dr. Calabrese because of transfer factor immunomodulatory therapy.

S - PATIENT OF DR. KANTER

For years I've been plagued with classic allergy symptoms as well as many mysterious symptoms and illnesses: frequent infections; fatigue; roving muscle & joint pain; rupturing fragile capillaries; chronically low white and red blood cell counts; irritable bowel syndrome; increasing allergies to medications, my environment and foods with severe weight loss from progressive food allergies.

Unfortunately, I had to take an early retirement from my public school teaching career because of my increasing health challenges.

Dr. Calabrese is the only physician to identify the hereditary cellular immune deficiency that caused my numerous health problems.

Prior to treatment with Dr. Calabrese, I had anaphylactic shock and multiple hospitalizations because of my allergic-immune problems. An Epi-pen was not an answer... but it kept me alive until I got the transfer factor immunomodulatory therapy, which is specific for my cell-mediated immunity problem.

My life is now normal. I can comfortably reassure Dr. Kanter that this has not been a long lasting placebo effect. It was incredible how well I was doing after only the first six months of transfer factor immunomodulatory therapy.

S - PATIENT OF DR. KANTER

My health had declined so much from this allergic-immune problem that everyone in my family and Bible study group had given up hope. . . while I just kept praying for a miracle.

I had no idea there are some immune problems that aren't very common, so there's little interest in them.

No Medicare carrier should ignore this specific, safe and extremely effective therapy because there's not much need. Even if it helped one person, that person has a right to this care.

I never would have left my precious first-graders and the teaching career I so cherished if I had been properly diagnosed and treated with the transfer factor when my health first started to decline.

I declare on this, the 13th day of December, 2007, in the city of Laguna Hills, CA, that this

information is true and correct to the best of my knowledge.

Beverly Patricia Meyer

T - MEDICAL EXPERTS

Alan S. Levin, M.D., J.D.- for petitioners

Pro bono testimony, no financial interest, no conflict of interest, Officer of the Court

Lewis Kanter, M.D. - for DHHS CMS

Dr. Lewis Kanter did not disclose he's on the NHIC Carrier Advisory Committee where he works at the pleasure of NHIC Medicare Contractor Dr. Bruce Quinn and where he sponsors majority-opinion allergy-immunology LCDs for reimbursement and where he participated in a second non-reimbursement of transfer factor LCD in 2007.

Dr. Quinn and Dr. Kanter intentionally and negligently violated multiple legal requirements of BIPA 2000 Sec 522 to obstruct justice. Dr. Lewis Kanter expressed outrage to DHHS DAB Judge Keith Sickendick that CMS FOIA released this information to us, the release of which is mandated in the Medicare Program Integrity Manual and under the Freedom of Information Act 5 USC § 552.

We did not receive this information until after the 12-19-07 OMHA hearing with Judge Gould. NHIC uses Dr. Lewis Kanter as their highly paid expert witness. EDS - NHIC was given all our confidential practice and patient informa

T - MEDICAL EXPERTS

tion without any confidentiality agreement to protect us. Dr. Lewis Kanter is a competing community allergist for the past three decades. Dr. Kanter has never seen a patient that failed to get well with Dr. Calabrese. Dr. Calabrese has successfully treated severely impacted allergy-immunology patients that Dr. Kanter saw first and was unable to treat because they had extensive allergies, including allergic hypersensitivity to chemicals, and abnormal cell mediated immunity.

SPECIALTIES

Alan S. Levin, M.D., J.D.- for petitioners

Allergy & Immunology – minority opinion

Dermatology

Clinical pathology – subspecializing in oncology

Attorney - specializing in environmentally induced cancer and autoimmune disorders.

Lewis Kanter, M.D. - for DHHS CMS

Allergist immunologist: majority-opinion

UNDERGRADUATE

Alan S. Levin, M.D., J.D.- for petitioners

High School: Austin, Chicago, Illinois

College: University of Illinois, Champaign-Urbana, Illinois 1956-1960 B.S. Chemistry in L.A. with Honors.

T - MEDICAL EXPERTS

Lewis Kanter, M.D. - for DHHS CMS

University of California, Irvine, B.S. 1969

GRADUATE & PROFESSIONAL SCHOOL

Alan S. Levin, M.D., J.D.- for petitioners

University of Illinois (Chicago Medical Center)
School: M.S. in Biochemistry, 1963.

Thesis: Metabolism of Serum Albumin in Rats with
Cirrhosis of the Liver, 1963.

Medical University of Illinois (Chicago Medical
Center) School: M.D. 1964

Alpha Omega Alpha Honor Medical Society, 1963

Lewis Kanter, M.D. - for DHHS CMS

Georgetown University School of Medicine M.D.
1973

POSTGRADUATE

Alan S. Levin, M.D., J.D.- for petitioners

Internship: Children's Hospital Medical Center
(Harvard Service), Boston, Mass. 1964-5.

Fellowships: Traineeship Grant, Harvard Medical
School 1964.

Research Assistant, Children's Hospital Boston,
1965.

USPHS Hematology Training Grant, UCSF Medical
Center 1969- 1971.

American Cancer Society Faculty Research Award,
1971-1974.

T - MEDICAL EXPERTS

Law School J.D. Golden Gate University, San Francisco. August 1, 1995

Admitted to California State Bar December 7, 1995, State Bar No. 178790; Admitted to Texas State Bar October 7, 1997, State Bar No. 24003244; Admitted to Nevada State Bar October 13, 1999, State Bar No. 007062; Admitted to California, Texas, and Nevada Federal District and Appeals Courts; Admitted to United States Court of Appeals for The Armed Forces May 7, 1999, Admission No. 31507; Admitted to U.S. Patent & Trade Office, Registration No. 53,210 January 28, 2003.

Lewis Kanter, M.D. - for DHHS CMS

Georgetown University School of Medicine & National Naval Medical Center in Bethesda, Maryland; Allergy Immunology Fellowship

MILITARY

Alan S. Levin, M.D., J.D.- for petitioners

USNR attached to USMC as Flight Surgeon 1966-1968.

Silver Star Medal, Bronze Star Medal with Combat "V"; First through Fourth Air Medals, Combat Action Ribbon, Presidential Unit Citation; Navy and Marine Corps Commendations, Vietnam Service; Medal with one bronze campaign star and Fleet Marine Force Device; National Defense Service Medal, Republic of Vietnam Meritorious Unit Citation (Gallantry Cross Medal), Republic of Vietnam Meritorious Unit Citation (Civil Actions Medal), Republic of Vietnam Campaign Medal,

Honorable Discharge November 1969

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Lewis Kanter, M.D. - for DHHS CMS

United States Navy - 10 years; US Army Reserve
6252nd US Army Hospital, Ventura CA - 12 years

CALIFORNIA MEDICAL BOARD

Alan S. Levin, M.D., J.D. - for petitioners

Member, Medical Quality Review Committee,
#4 Board of Medical Quality Assurance
California Medical Board, State of California,
November 1982 - November 1987 and

August 1990 - November 1993

Distinguished Service Citation, State of California
Sept. 14, 1987.

Lewis Kanter, M.D. - for DHHS CMS

Not applicable

CERTIFICATIONS

Alan S. Levin, M.D., J.D.- for petitioners

Certified Diplomate American Board of Allergy and
Immunology, 1975.

Certified Diplomate American Board of Pathology -
Clinical Pathology, 1977.

Lewis Kanter, M.D. - for DHHS CMS

Fellow American Board of Asthma, Allergy & Immunology

T - MEDICAL EXPERTS

MEMBERSHIPS

Alan S. Levin, M.D., J.D.- for petitioners

Fellow American College of Emergency Physicians.

Fellow College of American Pathologists

Fellow American Society of Clinical Pathologists.

Member American Academy of Allergy & Immunology.

Member American Medical Association.

Member American Academy of Environmental Medicine.

Lewis Kanter, M.D. - for DHHS CMS

American College of Asthma, Allergy & Immunology

Academy of Asthma, Allergy & Immunology

American Medical Association

Association of Military Allergists

American Academy of Asthma, Allergy and Immunology

Gold Coast Allergy Society

Los Angeles Allergy Society

California Society of Allergy & Clinical Immunology

Western Society of Asthma Allergy & Immunology

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ACADEMIC APPOINTMENTS

Alan S. Levin, M.D., J.D.- for petitioners

Adjunct Instructor in Pediatrics

Department of Pediatrics

University of California San Francisco

1971-1972

Assistant Professor of Immunology

Department of Dermatology

University of California San Francisco

1972-1978

Adjunct Associate Professor of Immunology

Department of Dermatology

University of California San Francisco

1978-1988

Director of Laboratory of Immunology

University of California and Kaiser

Foundation Research Institute Joint

Program Project

San Francisco, California

1971-1974

Attending Physician, Dept. of Medicine

Mt. Zion/University of California San Francisco

Hospitals 1971 - Present

Lewis Kanter, M.D. - for DHHS CMS

USC Keck School of Medicine, Assoc. Clinical Professor

T - MEDICAL EXPERTS

PRIVATE MEDICAL PRACTICE

Alan S. Levin, M.D., J.D.- for petitioners

Private Practice of Medicine
450 Sutter, Suite 1400 and 500 Sutter, Suite 512
San Francisco, California 94108
1981-present

Lewis Kanter, M.D. - for DHHS CMS

President and CEO
Coastal Allergy Care
2412 N. Ponderosa Dr. # B111
Camarillo, California 93010

LABORATORY

Alan S. Levin, M.D., J.D.- for petitioners

Private Director Division of Immunology
Practice: Western Laboratories

Oakland, California

1974-1977

Medical Director

MML/Solano Laboratories

Division of Chemed-W.R.Grace, Inc.

Berkeley, California 1977-1979

Medical Director

Levin Clinical Laboratories, Inc.

San Francisco, California

1979-1981

T - MEDICAL EXPERTS

Lewis Kanter, M.D. - for DHHS CMS

Not applicable

PRIVATE LAW PRACTICE

Alan S. Levin, M.D., J.D.- for petitioners

Practice of Law:

Counsel to the Firm of White & Meany
3185 Lakeside Drive
Reno NV 89509
6/15/1997-1/15/2001

Private Practice of Law:

Alan S. Levin, MD, JD
P.O. Box 4703
Incline Village, NV 89450
1/15/2001- Present

Lewis Kanter, M.D. - for DHHS CMS

Not applicable

TRANSFER FACTOR IMMUNOMODULATORY THERAPY

Alan S. Levin, M.D., J.D.- for petitioners

Daubert – qualified; Forty years of clinical experience including TF use in this patient subset with combined Th1 - Th2 immunoregulatory defect ; Extensive research and peer-reviewed publication on TF

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Lewis Kanter, M.D. - for DHHS CMS

Not Daubert – qualified; No experience with TF

ALLERGIC HYPERSENSITIVITY TO CHEMICALS

Alan S. Levin, M.D., J.D.- for petitioners

Daubert – qualified; Forty years of experience with patients with chemical sensitivity including patients with this combined Th1 – Th2 immunoregulatory defect;

Lewis Kanter, M.D. - for DHHS CMS

Not Daubert – qualified; In his declaration, Dr. Kanter wrote: "There is no recognized diagnosis of Multiple Chemical Sensitivities."

CELL MEDIATED IMMUNITY

Alan S. Levin, M.D., J.D.- for petitioners

Daubert – qualified; Extensive clinical experience, research and publication in cell mediated immunity /DTH

Lewis Kanter, M.D. - for DHHS CMS

Not Daubert – qualified; Cell mediated immunity is not Dr. Kanter's specialty; No research or publications in the field of cell mediated immunity

T - MEDICAL EXPERTS

MOLD ALLERGY & FUNGAL DISEASE

Alan S. Levin, M.D., J.D.- for petitioners

Daubert – qualified; Extensive clinical experience, research and publication in mold allergy and fungal diseases including patients in this subset who typically present with significant mold allergy.

Lewis Kanter, M.D. - for DHHS CMS

Not Daubert – qualified; No research or publications in the field of mold allergy or fungal disease

FIRST REPORTS

Alan S. Levin, M.D., J.D.- for petitioners

First reports of immunotherapy for immune deficiency disorders. Now a widely accepted therapeutic approach for immune deficiency and cancer.

First reports of the genetic switch mechanism refuting the long held Aone gene-one enzyme theory. Now a widely recognized phenomenon.

First report in peer reviewed medical literature of human T cells.

First report in peer reviewed medical literature of transmissible immunogens in human cancer. Now a widely recognized phenomenon.

T - MEDICAL EXPERTS

Report in Peer Reviewed Literature of findings from Anderson v. Cryovac, the case which is featured in the Book/Movie *A Civil Action* by J. Harr.

First report of Ribosomal Inhibitory Protein Therapy in AIDS

Follow up report on Phase II trial of Ribosomal Inhibitory Protein Therapy in AIDS

Lewis Kanter, M.D. - for DHHS CMS

No first reports

BIBLIOGRAPHY

Alan S. Levin, M.D., J.D.- for petitioners

Published over 65 full length articles and 45 abstracts in peer-reviewed medical literature. The primary subjects are immunology, immunopathology, cancer biology, and treatments.

Food Allergy and Intolerance

Editors: Jonathan Brostoff, MA, DM, DSc(Med), FRCP, FRCPPath and Stephen J Challacombe, PhD, BDS, FRCPPath, FDSRCSE, FmedSci; Alan Levin MD – Chapter 60: Transfer Factor and Allergies; WB Saunders – 1989.

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2. Levin AS; **Transfer Factor Therapy**; Southern Medical Journal, vol 69, no 12, pp 1465-1467, 1975
3. Spitzer LE, Levin AS, Fudenberg HH; **Transfer factor II: results of therapy**; Birth Defects Orig Artic Ser. 1975;11(1):449-56.
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7. Levin AS, Spitzer LE, Fudenberg HH.; **Transfer factor I: methods of therapy**; Birth Defects Orig Artic Ser. 1975;11(1):445-8.
8. Levin AS; **Editorial: Transfer factor therapy: current status**; South Med J. 1975 Dec; 68(12):1465-7.

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9. Wybran, J., Levin, A.S., Spitzer, L.E. and Fudenberg, H.H.:
Rosette Forming Cells, Immunological Diseases and Transfer Factor; New England Journal of Med. 228: 710-713, 1973.
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11. Levin, A.S., Spitzer, L.E., Stites, D.P., and Fudenberg, H.H.; **A genetically determined cellular immunologic deficiency: Clinical and laboratory responses to therapy with transfer factor;** Proc. Natl. Acad. Sci. USA 67: 821-828, 1970.
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Discussion paper: tumor-specific transfer factor therapy in osteogenic sarcoma: a two-year study; Ann N Y Acad Sci. 1976; 277(00):621-7.
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14. Levin, A.S., Byers, V.S., Fudenberg, H.H., Hackett, A.J., Johnston, J.O., and J.E. Wybran: **Osteogenic sarcoma: Immunologic parameters before and during therapy with tumor specific transfer factor;** J. Clin. Invest 55: 487-499, 1975.

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15. Spitzer LE, Levin AS, Wybran J.; **Combined immunotherapy in malignant melanoma. Regression of metastatic lesions in two patients concordant in timing with systemic administration of transfer factor and Bacillus Calmette-Guérin**; Cell Immunol. 1976 Jan;21(1):1-19.
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17. Fudenberg, H.H., Wang, A-C, Pink, J.R.L., and Levin, A.S.: **Studies on a bi-clonal gammopathy: Evidence for a unique genetic mechanism controlling immunoglobulin synthesis**; J. Immunol. 107 (3): 927-928, 1971.
18. Levin, A.S., Fudenberg, H.H., Hopper, J.E., Nisonoff, A., and Wilson, S.K.: **Immunofluorescent evidence for control of synthesis of variable regions of light and heavy chains of IgG and IgM by same gene**; Proc. Natl. Acad. Sci. USA 68: 169-171, 1971.
19. Byers, V.S., Levin, A.S., Hackett, A.J., and Fudenberg, H.H.; **Tumor specific cell mediated immunity in household contacts of cancer patients**; J. of Clin. Invest. 55: 500-517, 1975

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29. Girão E, Levin AS, Basso M, Gobara S, Gomes LB, Medeiros EA, Barone AA, Costa SF; **Trends and outcome of 1121 nosocomial bloodstream infections in intensive care units in a Brazilian hospital; 1999-2003.** Int J Infect Dis. 2008 Jun 4.

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T - MEDICAL EXPERTS

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Antifungal drug susceptibility profile of Pichia anomala isolates from patients presenting with nosocomial fungemia; Antimicrob Agents Chemother. 2007 Apr;51(4):1573-6. 2007 Jan 29.

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PATENTS

Alan S. Levin, M.D., J.D.- for petitioners

Two patents for immunotherapy regimens

//

Lewis Kanter, M.D. - for DHHS CMS

None

U - SENATOR BARBARA BOXER



RE: BOMBS
AND AIRPORT
SECURITY

Mr. David Sayan
Associate Regional Administrator
Division of Medicare
Health Plans Operations
90 7th Street, Suite 5-300 (5W)
Centers for Medicare Services
San Francisco, CA 94103-6706

Dear Mr. Sayan:

Enclosed please find a copy of the correspondence Senator Boxer received from Ms. Joan Webb of San Rafael, CA, regarding a matter with the Center for Medicare Services (CMS)

Ms. Webb informs the Senator that she receives treatment from Dr. Dorothy Calabrese, for her extensive allergies, including chemical sensitivity, and abnormal cell mediated immunity.

She states that her underlying disorder is a Th1-Th2 immunoregulatory defect, and that it

U - SENATOR BARBARA BOXER

severely impacts her quality of life when untreated. It is her contention that she reacts dramatically to her treatments and that they are essential in order for her to live a normal and productive life.

She asserts that said treatments are fully supported by the California Medical Board, which has endorsed Dr. Calabrese's work for 27 years.

It has come to my attention, however, that CMS is refusing to reimburse Dr. Calabrese, for Ms. Webb's treatment on the grounds that it is not medically necessary. Ms. Webb states that if Medicare does not consent to reimbursement shortly, said physician will have to terminate her care. It is her contention that irreversible damages would occur as a result, and that her long-term health would be greatly jeopardized. As such, she requests that the medically-vital treatments she receives be granted coverage under Medicare.

As this matter concerns the health and well-being of Ms. Webb, I am respectfully referring the attached for your review and consideration. Any information you can provide in response to the ~~concerns~~ expressed by Ms. Webb will be most appreciated.

U - SENATOR BARBARA BOXER

Thank you for your constituent letter. I will forward it to Senator Boxer's San Francisco office.

Attention: Chico Nellens,

Sincerely,

12/17/08
Elvira
Enclosure
cc: Ms. Jean Webb

434a

BEST AVAILABLE COPY

V - T H E R E S A D E B E L L , R . N .

Dear Mr. Messer,

We have received your letter of November 13, 2003, addressed to Dr. Arthur Lurvey, our former Carrier Medical Director, regarding reimbursement for "preservative-free allergy extracts" and "transfer factor." In your letter you describe your search for a definitive diagnosis of your complex immune disorder, your difficulty in finding successful treatment for this, and your very successful response to the regimen administered by Dr. Dorothy Calabrese. This regimen involves the use of preservative free allergy extracts and transfer factor, and you are concerned about Medicare reimbursement for these agents. We have reviewed our policy and claims for these agents. NHIC does cover allergen immunotherapy, which describes the use of preservative free allergy extracts. NHIC, however, does not cover transfer factor. Although you may be receiving this agent from your physician in her office, it is an **over-the-counter medication** and is usually self-administered. Medicare does not cover for medicines with this description. Services must be 'reasonable and necessary for the . . . treatment of illness. . . ." As long as preservative free allergy extracts remain reasonable and necessary for the treatment of your condition, NHIC will reimburse claims for these agents.

Theresa DeBell, R.N., Medical Review 12-02-03
cc: Senator Barbara Boxer

V - T H E R E S A D E B E L L , R . N .

From: De Bell, Theresa
[mailto:theresa.debell@eds.com]
Sent: Friday, April 25, 2008 2:21 P.M.
To: Lurvey, Arthur
Subject: Transfer Factor LCD
Forwarded: Harry Feliciano, M.D., Medicare
Medical Director, GBA Palmetto

Arthur Lurvey, M.D.
Medical Director
National Government Services, Inc.
arthur.lurvey@ugswlp

Dr. Lurvey,
Doniece just told me that you had a question about our transfer factor [immunomodulatory therapy] LCD. This LCD was generated because of a problem with a particular provider, and at present there is ongoing litigation with this provider, NHIC, EDS, CMS, and others about our policy. I believe that we had discussed retiring this policy at some time recently, but because of the litigation it was retained.

I will be back in the office on Monday, if you have any questions about this. Thanks

Terry DeBell
NHIC Corp.

Excerpt Reconsideration Brief

Heckler v. Ringer

The District Court cites this case as "instructive." We respectfully disagree:

a) **Medicare, Medicaid & SCHIP Benefits Improvement & Protection Act of 2000 Sec 522, [BIPA 2000]** Ringer et al. challenged a non-reimbursement NCD for bilateral-carotid-body resection [hereinafter BCBR] for respiratory distress. There was no avenue for independent NCD or LCD appeals until the Benefits Improvement and Protection Act 2000 Sec 522. The District Court compared our case with the procedural side of Ringer. But the comparison fails because Congress in BIPA 2000 established a specific two level appeals process for LCDs and NCDs. We spent 20 months doing our Joint 2005 LCD appeal and prevailed. There was no LCD docket, which automatically reinstates reimbursement. Unlike similarly situated Medicare Part B beneficiaries who prevail, our class of patient was denied any enforcement and are now appealing: Ninth Circuit case no. 07-56622.

b) **Not a medical turf war** In the 1980's, BCBR was reported to relieve dyspnea in patients with severe COPD during both rest and exercise mainly because of a large fall in respiratory rate, minute ventilation, and, therefore, probably dynamic hyperinflation. However,

most patients developed worsened hypoxemia and hypercapnia, and death may have been hastened by such surgery. See: Stulberg MS, Winn WR: *Bilateral carotid body resection for the relief of dyspnea in severe chronic obstructive pulmonary disease*. Chest 1989; 96: 1123-1128. The BCBR NCD was based on good medical-surgical practice. The TF literature is now sixty years old and continues to build on our understanding of the exact cytokine mediator and other pathways that underlies the hereditary combined Th1-Th2 immunoregulatory defect, our class of patient has.

c) Constitutional and criminal violations:

In Ringer , there were no Constitutional / criminal violations.

d) Medicare Part A v. Part B:

Ringer is Part A which offers substantial contractual, timeline and enforcement protections. Part B medical practices are unprotected fragile small businesses.

e) Fraudulent representation of diagnosis

There were no fraudulent representations of diagnosis in Ringer. DHHS has used a straw man argument falsely state as a truism that our patients have MCSS, a wastebasket diagnosis for patients with symptoms of chemical sensitivity of no known etiology.

The District Court on 07-25-08 also wrote that our patients have MCSS, which they do not, affirming all of Dr. Bruce Quinn's false statements:

A priori there can be no treatment.

A priori there can be no supporting clinical or scientific evidence in the 'normative' literature.

A priori there can be no documentation in the patients' charts supporting treatment.

A priori there can be no Daubert-qualified medical expert on the treatment.

A priori- the excellent clinical recoveries of this class of patient are a placebo response.

A priori - the attending physician records are anecdotal.

A priori - the supporting patient statements are testimonials.

A priori - the medical treatments are 'bizarre'

A priori - 'Dr. Calabrese cannot tell right from wrong or fantasy from reality'

A priori - all the claims must be rejected retroactively and prospectively

A priori - any ALJ would render an unfavorable OMHA decision, so it is harmless error that Judge Koldewey wrote and signed the decision with Judge Gould's name, when it was physically impossible for the decision to be his.

5 U.S.C. §§ 702

Constitutional due process, equal protection and criminal violations are not reviewable under Administrative Procedure Act [hereinafter APA]. Furthermore, there is no APA redress available to us for this. For the past six years, DHHS could have voluntarily remedied these violations and instead paid far more to the Contractor's attorney John A. Conkle than it would ever have cost for the care for all the patients.

Baker v. U.S.

On 07-25-08, the Court relied on this case. In this FTCA case, Baker alleged negligent failure of DHHS to obey a mandatory regulation. The 9th Circuit remanded the case back and ordered the District Court to consider which state's substantive law applies and whether that state provides a cause of action against private parties that was analogous. We are not seeking this type of remedy.

Bodimetric Health Services, Inc. v. Aetna
Life & Casualty

On 07-25-08, the Court relied on this case. Part A Medicare; Bodimetric sued for monetary damages re: Aetna's method of processing its claims & argued Aetna should pay, not Medicare. Bodimetric successfully challenge benefits determinations on an individual basis in many administrative proceedings instead of being able to challenge them as a LCD. BIPA 2000 Section

522: LCD appeals resolved this issue. We handled the similar issues in our Joint 2005 LCD appeal, which we prevailed in.

Bowen v. Georgetown University Hospital

The Federal Court said we cited this case in the 07-25-08 decision. This is a Part A Medicare case:

We didn't cite the case but quoted:

We have never applied the principle of those cases to agency litigating positions that are wholly unsupported by regulations, rulings, or administrative practice.

Justice Anthony Kennedy,

***Bowen v. Georgetown University Hospital,
488 U.S. 204 (1988)***

The U.S. Attorney made a materially false statement to the District Court and has made extraordinary litigating position claims not supported by regulations, rulings, statutes or the U.S. Constitution.

Califano v. Sanders

On 07-25-08, the Court relied on this case. Mr. Sanders was denied Social Security Disability and re-filed the exact same case 7 years later without any change in his medical condition.

DHHS refused to reopen the case. He challenged that his case was not reopened. We have never re-filed a case.

Clarke v. Securities Industr

On 07-25-08, the Court relied on this case. This is a non-Medicare case, which states a case must be '**arguably within the zone of interests to be protected or regulated by the statute or constitutional guarantee in question.**' Our cases do not involve "zone of interests."

Hironymous v. Bowen

On 07-25-08, the Court relied on this case. Hironymous sought Supplemental Security Income benefits under Mandamus and Venue Act of 1962, 28 U.S.C. Sec. 1361. His resources exceeded the maximum amount established by law and was denied. We have no such cap and did not file under mandamus.

Kaiser v. Blue Cross of California

The Federal Court cited this Part A Medicare case in the 07-25-08 decision. In a *prior* case, the Kaisers knew they had been overpaid by more than one million dollars and requested an extended repayment plan. In the course of events, they claimed monetary damages for defamation and invasion of privacy. Our 07-25-08 Federal stay decision states:

"Just as the court reasoned in Kaiser, "[h]ad the [plaintiffs] never accrued an overpayment in the first place, they never would have brought this case."

It is highly prejudicial, that the District Court presumes we owe the illegal retroactive overpayment predicated on reversal of the previous carrier's policy by the Contractor without any notice whatsoever.

We similarly object to the "Factual background" in the 07-25-08 decision, which contains highly inflammatory false statements from DHHS. No Medicare Part B physician should ever be subjected to slander without any defense, while being denied any access to the Federal Rules of Evidence to prove these are untrue.

U.S. v. Mitchell

In the 07-25-08 decision, the Federal Court cited this non-Medicare FTCA claim for monetary damages in connection with management of forest resources on allotted Quinault Reservation lands. We have no claim for monetary damages.

U.S. v. Nordic Village

In the 07-25-08 decision, the Federal Court cited this non-Medicare case, which states Section 106(c) of the Code does not waive U.S. sovereign immunity from an action seeking monetary recovery in Chapter 11 bankruptcy. We have no such claim and no bankruptcy.

Tucson Airport Auth. V.

General Dynamics Corp

In the 07-25-08 decision, the Federal Court cited this non-Medicare case, which actually supports our position:

Unless an officer of the United States acts without statutory authority, the officer's acts are the acts of the sovereign, immune from suit to the same extent as the United States itself is immune.

Aminoil U.S.A., Inc. v. California State Water Resources Control Bd. 674 F.2d 1227, 1234 (9th Cir. 1982)

X - JUDGE STANLEY S. SADUR

Department of Health and Human Services
Social Security Administration
Office of Hearings and Appeals

Decision

In the case of: Marna Slocum, Claimant

Claim for:

Supplementary Medical Insurance Benefits

Marna Slocum, Beneficiary, HIC: 565-36-3489A

Carrier / intermediary: Blue Shield of Texas

Docket Number 000-99-0953

This case is before the undersigned Administration Law Judge on a request for hearing filed on November 10, 1988. An oral hearing was held on March 7, 1989 in Honolulu, Hawaii. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits, the testimony at the hearing, and the arguments presented.

ISSUES

The general issue is whether payment may be made under Part B of Title XVIII of the Social Security Act for transfer factor immunomodulatory reagent furnished to the beneficiary between February 5 and October 2, 1987. The specific issue to be decided is whether transfer factor is reasonable and necessary for the treatment of multiple chemical allergies.

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DECISION

It is the decision of the undersigned Administrative Law Judge that the transfer factor immunomodulatory reagent is covered under the provisions of Title XVIII of the Social Security Act. Therefore, the carrier is directed to determine the reasonable charge for the covered item and to make appropriate payment under Part B of Title XVIII.

EVALUATION OF THE EVIDENCE

The record establishes that Marna Slocum, the Medicare beneficiary suffers from multiple allergies and must live a restricted existence in a chemical free environment to avoid severe symptomatology. In 1986 she was exposed to a chemical irritant (arsenic sprayed on a golf course), causing a severe, life-threatening reaction. She was referred by her treating physician to a specialist in Texas. Upon admission to a Texas hospital in April, 1986, she was complaining of a severe weakness, blurred vision, muscle spasms, swelling and weight loss. (EX 22) She was placed in chemical isolation and treated with vitamin C, histamines, potassium and sodium bisalts and transfer factor to stimulate the immune system. She experienced no difficulty or side effects from the transfer factor and was discharged improved after about three weeks of treatment. She was continued to improved since that time, having shorter and less severe reactions. She now takes transfer factor only as

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needed. Her treating physician, Dr. Ewing, stated in a letter of March 7, 1989 that her reactions have become progressively less severe and she needs the transfer factor less often than before. Since no other aspects of her treatment plan have been changed, he attributes the improvement to the use of transfer factor. (EX. 23)

The Medicare carrier has refused to cover the cost of the transfer factor furnished to the beneficiary on the basis that the treatment is still considered experimental and therefore does not meet the Statutory criteria that the item or service be reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member. A carrier physician who reviewed the case stated that he could find no controlled studies of the usefulness of transfer factor in allergy treatment. He also noted that the treatment could have undesirable side effects including autoimmune disorders and lymphoproliferative disorders. (EX 6 p.2)

The beneficiary has presented a considerable amount of written material on the subject of chemical sensitivity as evidence. This evidence indicates that the chemical sensitivity is a relatively recent field of research, but the one that is increasingly being accepted as a legitimate concern by the general medical community. The beneficiary has presented evidence that several

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private insurers, including Blue Shield of Hawaii, now cover the use of transfer factor (ex 19).

In addition, the beneficiary has submitted the results of a study conducted by Said Youdim, Ph.D. of the Environmental Health Center, Dallas, Texas on the treatment of the environmentally ill patients with transfer factor. (EX 20) Half of the 50 patients involved in the study demonstrated increases in the mean number of positive responses from 1.36 to 3.4 and reaction size increased from 5.2 to 15.5, which is a near normal rate.

The issue in this case is whether the transfer factor is a reasonable and necessary for treatment of the beneficiary's illness. Section 1862(a) of the Social Security Act states in pertinent part: "Notwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expense incurred for items or services— (A) which, are not reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,"

The term "reasonable and necessary" is not further defined in the Statute or existing regulations. However, on January 30, 1989, the Health Care Financing Administration (HCFA) published, in the Federal Register, a Notice of Pro-

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posed Rulemaking (54 F.R. 4302, January 30, 1989) setting forth proposed criteria and procedures for HCFA decisions as to whether and under what circumstances specific health care technologies could be considered reasonable and necessary and therefore covered under Medicare. There are only proposed regulations and, accordingly have no force or effect as yet. However, in the opinion of the undersigned, they may be relied upon as representative of agency policy in this area.

HCFA proposes to find a service reasonable and necessary if it is (1) safe and effective; (2) not experimental or investigational; (3) cost-effective; and (4) appropriate. Treatments that are less safe and effective than would usually be desirable may still be found to be reasonable and necessary in cases of severe or life-threatening illness where no safer or more effective treatments are available. In general, experimental drugs or services are those not approved by the FDA and furnished only for research purposes. In the absence of a national coverage decision by HCFA, Medicare contractors may determine whether a specific item or service is reasonable and necessary.

Although the carrier denial of coverage is this case was based upon a finding that they were referring to lack of FDA approval, (since the substance has been used by the medical com

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munity for many years and is covered by some insurance companies), but rather to lack of clear evidence of safety and effectiveness. The factors of appropriateness and cost effectiveness are not at the issue. As noted above, proposed regulations recognize that there is no single set of criteria for judging safety and effectiveness, but rather, a sliding scale. More risky or less well documented treatments may be acceptable in situations where the claimant's life or health are seriously threatened and no better or safer course of treatment is available.

In the instant case, the undersigned is convinced that the transfer factor has been instrumental in the beneficiary's recovery from an acute episode of chemical sensitivity and in maintaining her immune responses within more normal limits. Except for the introduction of the transfer factor, the claimant's attributes her improvement to the use of the transfer factor. Although there is a potential for side effects, none have been reported. The claimant suffers from a number of debilitating allergies for which no other effective treatment could be rendered. Accordingly, the undersigned concludes that the use of transfer factor for the treatment of the beneficiary's multiple allergies was safe and effective in this case and that the transfer factor was reasonable and necessary for treatment of the beneficiary's illness.

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FINDINGS

After careful consideration of the entire record, the Administrative Law Judge finds that:

1. From February 5 to October 2, 1987, the beneficiary received injections of transfer factor immunomodulatory reagent.
2. The beneficiary is diagnosed as having multiple chemical allergies
3. The injections of transfer factor immunomodulatory reagent have been shown to be safe and effective treatment for the beneficiary's illness.
4. The injections of transfer factor immunomodulatory reagent were reasonable and necessary for the treatment of the beneficiary's illness or injury.

DECISION

It is the decision of the undersigned Administrative Law Judge that the transfer factor immunomodulatory reagent is covered under the provisions of Titles XVIII of the Social Security Act. Therefore, the carrier is directed to determine the reasonable charge for the covered items and to make appropriate payment under Part # of Title XVIII

Stanley S. Sadur
Administrative Law Judge
Office of Hearings and Appeals
24th floor, 100 Van Ness Ave.
San Francisco, Ca 94102

Date APR 25 1989

Y - JUDGE ARTHUR CAHN

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Departmental Appeals Board

**Medicare Operations Division Room 633.F,
HHH Building 200 Independence Avenue, S.W.
Washington, DC 20201**

Ms. Ella Balogh

1528 Halekoa Drive

Honolulu, HI 96821

**NOTICE OF ORDER OF MEDICARE
APPEALS COUNCIL REMANDING CASE TO
ADMINISTRATIVE LAW JUDGE**

What This Order Means

We have sent your case back to an Administrative Law Judge. In the enclosed order, we explain why we did this and what actions the Administrative Law Judge will take on your claim. In addition to what we directed the Administrative Law Judge to do, the Administrative Law Judge may also take any other action necessary to complete your claim.

The Next Action on Your Claim

An Administrative Law Judge will contact you to tell you what you need to do. If you have any questions you may contact your local hearing office.

Y - JUDGE ARTHUR CAHN

DHHS DAB

**ORDER OF MEDICARE APPEALS COUNCIL
REMANDING CASE TO ADMINISTRATIVE
LAW JUDGE**

In the case of Ella Balogh (Appellant)

**Claim for Supplementary Medical Insurance
Benefits**

The Administrative Law Judge issued a decision in this case on October 21, 1998. The beneficiary, Ella Balogh, has asked the Medicare Appeals Council to review this decision. The Medicare Appeals Council grants the request for review pursuant to 20 CFR 404.967 and 404.970 because there is an error of law. The Council hereby vacates the October 21, 1998 decision and remands this case to the ALJ for further proceedings, including a new decision. (See 20 CFR 404.977 and the notices published in the Federal Register on December 13, 1995 (60 FR 64065) and May 12, 1997 (62 FR 25844, 25849). The issue in this case is whether Medicare is obligated to pay for antigens furnished to the beneficiary between June 20, 1996 and May 20, 1996. Antigen therapy (also known as allergen immunotherapy) involves the periodic injection of specific allergenic extracts, or antigens, for the purpose of desensitizing the patient or building immunity to a substance believed to cause allergic reaction. It appears that the beneficiary received several types of antigens during the period at issue, and that the beneficiary self-injected these antigens. The intermediary de

Y - JUDGE ARTHUR CAHN

nied coverage for most of the antigens. As to these, the ALJ ruled that Medicare could not pay for the antigens, finding the beneficiary's treatment to be "experimental." We conclude that a remand is necessary for several reasons. It does appear that the beneficiary received several food antigens. The ALJ's decision contains a discussion of a substance known as "transfer factor." The decision does not show that the ALJ performed a de novo evaluation of the beneficiary's coverage claims. The fair hearing officer denied payment for the antigens in question on the ground that they were "investigational," "lacked proven effectiveness," were not FDA-approved, or constituted treatment that was not the "standard of practice" for the treatment of allergic sensitivity. According to the fair hearing officer, an iromunotherapy technique used to treat the beneficiary - skin end point titration - "often results in the preparation of antigens that are not effective and/or do not comply with the usual medical practice for patients with allergic conditions." There is no indication that the ALJ investigated these findings, either by asking the carrier to produce the information or medical policies supporting its coverage denials, or by obtaining testimony from a qualified medical expert. Because the hearing was nonadversarial and the beneficiary was not represented by an attorney, the ALJ had a duty to obtain the evidence sufficient to address the issues presented. See 20 CFR 404.944 In the absence of a

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national coverage decision (NCD), the Medicare contractor is responsible for determining whether a particular medical item or service is "reasonable and necessary." (See preface to Coverage Issues Manual (reprinted at 54 Fed. Reg. 34555 (August 21, 1989). The contractor often makes this determination on a case-by-case basis. When a coverage issue arises frequently, the contractor will often issue a local coverage or "medical review" policy that describes the circumstances under which the item or service will be considered reasonable and medically necessary and covered by Medicare. In developing a "policy, the contractor may rely on information and experience it has developed in its non-Medicare business; consult its medical staff, consultants, local medical societies, medical schools, and teaching hospitals; review the scientific literature; or use other appropriate resources. (See Medicare Carriers Manual § 7501.2 (9/94)(subsequently moved to Program Integrity Manual Chpt. 1, § 2.3)). A contractor's coverage determination, whether made on a case-by case basis or pursuant to a pre-existing statement of policy, is not binding on an ALJ, who is obligated to address the evidence and issues de novo. The ALJ's coverage determination should be based on an informed evaluation of the contractor's reasons for denying coverage as well as of the evidence upon which that contractor relied on. An ALJ may defer to a contractor's coverage policy in a given

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case, but such deference is warranted only if the policy is supported by appropriate evidence and is consistent with applicable statutes, regulations, and HCFA guideline5. (See Medicare Carriers Manual § 7501 (now Chpt. 1 of Program Integrity Manual)). In this case, the ALJ did not adequately develop the record and implied that the burden was wholly on the beneficiary to establish that the fair hearing officer and carrier had improperly denied coverage. The decision states that its coverage rulings were not based on findings that the antigens were not "reasonable and necessary" but were based instead on a determination that the antigens were categorically "excluded from coverage." However, antigens are covered benefits under section 1861(s)(2)(G) of the Social Security Act. Furthermore, to the extent that an antigen is found to be experimental, investigational, or lacking proven effectiveness, the coverage denial should be made under section 1862 (a) (1) (A), the "reasonable and necessary" provision. The ALJ's decision does not address whether the coverage requirements contained in 42 CFR 410.68 were satisfied. Section 410.63 says that Medicare will pay for a "reasonable supply" of antigens that are prepared for a specific patient if (1) the antigens are prepared by a physician who has examined the patient and developed a plan of treatment that includes dosage levels, and (2) the antigens are administered by a physician or by a "properly instructed person under

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the supervision of a doctor of medicine.]" 54 Fed. Reg. 4026 (January 21, 1989).

Instructions on Remand

On remand, the ALJ shall (1) give the beneficiary the opportunity for another hearing; (2) identify which claims are properly before him (and, if necessary, determine the status of the request for hearing allegedly filed on September 6, 1996); and (3) issue a new decision that addresses the relevant coverage issues *de novo*. The new decision shall identify the antigens associated with each date of service and contain coverage findings that cover each type of antigen in dispute. If a section 1842(1) finding is necessary, the physician must be made a party to the case. See HALLEX § 1-5-505(111)(D). To support the necessary coverage findings, the ALJ should obtain the information or policy supporting the carrier's determination not to pay for the antigens in question. The ALJ shall ask the beneficiary to submit any relevant medical records and, if necessary, assist the beneficiary in obtaining such records from her physician. If necessary, the ALJ shall also obtain medical expert testimony, preferably from an immunologist or allergist familiar with the standards of medical practice in the beneficiary's community, concerning (1) the beneficiary's condition and history of treatment, (2)

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the techniques used to diagnose and treat her, (3) the reasonableness of the carrier's coverage guidelines and whether they were supported by adequate evidence, and (4) the sufficiency of the medical documentation. In addition, the ALJ shall consider and make findings concerning the applicability of the national coverage decision (NCD) in Coverage Issues Manual's 50-53, which excludes from coverage certain types of food allergy. Finally, if it is determined that some or all of the antigens are covered, the ALJ shall obtain the necessary documentation - and make the necessary findings — concerning the applicability of Medicare's secondary payer provisions. Those provisions are found in section 1862(b) of the Act and in section 3328 of the Medicare Carriers Manual. The ALJ may take any further action not inconsistent with this remand order.

MEDICARE APPEALS COUNCIL



Marc R. Hillson
Administrative Appeals Judge
M.Terry Jotuison
Administrative Appeals Judge

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals
DECISION IN THE CASE OF
CLAIM FOR ELLA BALOGH

Y - JUDGE ARTHUR CAHN

STATEMENT OF THE CASE

The record shows that Medicare coverage for antigen therapy, which was provided to the beneficiary, Ella Balogh, between June 20, 1994 and May 20, 1996, was denied. The claim was also reviewed on the record by an independent Medicare Fair Hearing Officer, who issued a determination denying coverage on April 22, 1997. Dissatisfied with this outcome, the beneficiary filed a request for a hearing before an ALJ. On October 21, 1998, an ALJ decision was issued denying Medicare coverage for the antigen therapy. On October 10, 2001, the Medicare Appeals Council vacated the October 21, 1998 decision and remanded the case for further evaluation. In accord with the order of remand by the Medicare Appeals Council, additional medical evidence and testimony has been obtained and made a part of the record. A hearing was scheduled for June 21, 2002, but later rescheduled for several reasons including the claimant's inability to appear due to illness. After proper notice, the hearing was held on August 21, 2002, in Honolulu, Hawaii. The claimant personally appeared and testified. She is represented in this case by Frank Slocum, a non-attorney representative. At the hearing, Dr. Alexander Rolh, M.D., testified as a medical witness at the request of the Social Security Administration and Dr. George Ewing, M.D., testified as the beneficiary's treating physician and medical expert at the request of the beneficiary.

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The undersigned has carefully considered all of the documents and materials identified in the record as exhibits, the testimony at the hearing, and the arguments presented. It is the conclusion of the Administrative Law Judge that the antigen therapy at issue is covered under the provisions of the Medicare program.

EVALUATION OF THE EVIDENCE

Generally, antigen therapy, which is also referred to as allergen immunotherapy, involves the periodic injection of specific allergenic extracts, or antigens, for the purpose of desensitizing the patient or building immunity to a substance believed to cause allergic reaction. The beneficiary has been diagnosed with multiple chemical sensitivities. She has been found incapable of working and was awarded disability. She has described having been very restricted in her daily activity, having to stay in a certain safe zone, and having to sleep on the floor on a sheet to avoid exposure to environmental pollutants. She initially received treatment from Dr. George Ewing, M.D., in Honolulu, Hawaii. Dr. Ewing attempted to treat her symptoms, but which progressively worsened in spite of his efforts. The beneficiary received several types of antigens during the period at issue, and the beneficiary self-injected these antigens. Testimony at the first hearing established that the beneficiary's husband's health insurance company, acted as the primary insurer and paid approximately 70% of the total

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charges for the therapy. Payment for the remaining charges is being sought from Medicare, as the secondary insurer. On June 20, 1994, she was given a number of antigens: Candida, partridge, soy, apple and pear antigens, cotton, molds, cow's cheese antigens, dust mite, cat smuts, and more foods. The Fair Hearing Officer denied payment for the antigen therapy on the basis that it was "investigational", "lacked proven effectiveness", and that the skin end point titration method utilized to start the beneficiary on a course of treatment did not constitute treatment that was the "standard of practice" for treatment of allergic sensitivity.

The Medicare Appeals Council, upon remand, has directed the record be further developed to include opinion from a medical expert, familiar with the standards of practice in the beneficiary's community, qualified to address issues including the beneficiary's condition and history of treatment, and familiar with the techniques used to diagnose and treat her. Section 1862 of the Social Security Act provides coverage for certain items and services under Part B, where items and services are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (42 U.S.C. 1395y(a)(1)(A)). Under section 1861(s)(2)(G) of the Social Securi-

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ty Act, Medicare coverage can be provided for antigens where they are reasonable and necessary. A medical item or service can be considered "reasonable and necessary" where it has been determined to be safe and effective based on authoritative evidence, or in the alternative, where it is generally accepted in the medical community to be safe and effective for the condition for which it is used. See 54 Fed. Reg. 4304 (January 30, 1989). During the hearing, testimony was obtained from Dr. Alexander Roth, M.D., a specialist in immunology and allergy. Testimony was also obtained from Dr. George Ewing, M.D., who is certified as a specialist by the American Board of Allergy and Immunology and the former Chief of the Department of Allergy and Clinical Immunology from 1974-1987 at Straub Clinic and Hospital in Honolulu, Hawaii. Although Dr. Roth was not persuaded that the effectiveness of allergy treatment is recognized. Dr. Ewing opined that such treatments are effective for multiple chemical sensitivities, stated that he has referred others for such treatments, and reported that the beneficiary has significantly improved following antigen treatment. The undersigned has considered several factors in evaluating the opinions of Dr. Roth and Dr. Ewing. Dr. Ewing, as the treating specialist, is familiar with the beneficiary's condition, is qualified as a board certified immunologist and allergist to render an opinion on the issue at hand, and is more knowledgeable about the techniques used to diagnose and treat the

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beneficiary. Dr. Ewing has been the beneficiary's primary treating physician since 1981. He reported that the beneficiary received various forms of treatment without significant relief; but had not improved until started the antigen therapy. The usefulness of the therapy and technique was approved by the Panel on Allergy of the American Medical Association Council on Scientific Affairs, and has been widely used by physicians. In observing the beneficiary following the therapy, Dr. Ewing described the beneficiary as "significantly better." He noted that she has not required any antigen shots of any type for the last three years, and she has gained weight. Dr. Ewing stated, her "health situation is significantly improved and I consider this a direct benefit of the last course of treatment that she received. The opinion of a treating physician is generally entitled to great weight. In disability cases under Titles II and XVI of the Social Security Act, greater weight is given to a treating physician's opinion than to non-treating physician opinions. A treating source usually has reasonable knowledge of a patient's impairments based on a detailed, longitudinal history of the patient that cannot be gleaned solely from objective medical findings or one-time individual examinations. In giving great weight to Dr. Ewing's opinion, the undersigned notes that Dr. Ewing has been the beneficiary's treating physician in Hawaii for many

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years, and that he has had the opportunity to observe the beneficiary's condition both before her treatments. His report that the treatment significantly improved her condition to such extent that she has not required further therapy for years is not contradicted by the opinions of any other physician in the record. The antigen therapy at issue involved more than testing for food allergies, which are the focus of the national coverage decision (NCD) in the Coverage Issues Manual § 50-53. The claimant has chemical sensitivities to multiple allergens. In his testimony, Dr. Ewing specifically opined that, based upon his long-term evaluation of the beneficiary, the antigen therapy was reasonable and necessary for treatment other condition, and is "convinced" she is much improved due to the therapy provided over time. The undersigned is therefore persuaded that the record establishes that use of the antigen therapy here was reasonable and medically necessary. Based upon Dr. Ewing's opinion as the treating physician and other evidence in the record, the therapy has been effective in significantly improving the beneficiary's condition. Under the coverage requirements of 42 CFR 410.68; Medicare will pay for a "reasonable supply" of antigens that are prepared for a specific patient if(1) the antigens are prepared by a physician who has examined the patient and developed a plan of treatment that includes dosage levels, and (2) the antigens are administered by a physician or a "properly instructed person under the supervi

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sion of a doctor of medicine." As noted by the Medicare Appeals Council remand order, at page 4, the final rule adopting section 410.68 indicates that a properly instructed person may include a patient. See 54 Fed. Reg. 4026 (January 27, 1989). There is no evidence in the record that the beneficiary was other than a properly instructed patient under the supervision of a physician, and there is no indication that the periodic provision of antigens at issue here was not in accord with the intent of this provision. It is the decision of the undersigned ALJ that the antigen therapy at issue is covered under the provisions of Title XVIII of the Social Security Act, and therefore, is eligible for reimbursement to that extent allowed by the secondary payor provisions set forth in Section 1862(b) of the Social Security Act and section 3328 of the Medicare Carriers Manual. This decision applies only to the therapy and circumstances presented by the claim(s) in question upon the hearing of this matter, and does not create precedent for any other Medicare claims or services.

FINDINGS

After careful consideration of the entire record, the undersigned Administrative Law Judge makes the following findings:

1. The beneficiary received treatment for multiple chemical sensitivities. She received payment from her husband's health insurance

Y - JUDGE ARTHUR CAHN

carrier as the primary insurer for most of the treatment.

2. She was provided antigen therapy between June 20, 1994 and May 20, 1996.

3. The antigen therapy at issue was reasonable and necessary for the treatment of the beneficiary's illness between June 20, 1994 and May 20, 1996 and is therefore covered under the provisions of the Medicare Part B program.

4. The antigen therapy is eligible for reimbursement by Medicare, as the secondary payor, in an amount and to the extent allowed by the Medicare law and regulations.

DECISION

It is the decision of the undersigned Administrative Law Judge that the antigen therapy at issue is covered under the provisions of Title XVIII of the Social Security Act. Therefore, the carrier is directed to determine the reasonable charge for the covered therapy and to make appropriate payment to the extent allowed by the Medicare law and regulations.


Arthur S. Cahn
Regional Chief Administrative Law Judge

September 27, 2002
Date

Z - H A Y L E Y O T T O

DECLARATION OF HAYLEY OTTO

I was born with severe allergies and chemical sensitivities. Before I began treatment, I was unable to function at all, much less live a normal life. I had near constant violent allergic reactions.

We tried to eliminate the foods I was allergic to, but environmental triggers and the sheer number of unknown triggers foiled every attempt we made to figure out what I was allergic to and control my reactions with treatment from the local allergists.

Even worse, I often turned out to be far more allergic to the foods my parents substituted for any food we had to take out of my diet. I'm allergic to many preservatives, including the ones found in most antigens.

I had few friends, no hobbies, and few interests. My grades were poor. I could only be called functioning if the loosest definition of the word possible were used. When I was sick, I didn't want to play or read, or do anything else that children do.

When I was sick with obvious adverse allergic reactions at school, my fellow students were terrified of me, and would either ignore me or tor

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ment me depending on their moods. Most of the adults saw allergies as simply needing inhalers or other medicines. I was lonely, miserable, and unable to control my allergic reactions, or even understand them. I felt terrible crushing guilt that somehow I could control my environmental exposures better.

Even though my dad is a scientist and my mom is a registered nurse, it took them several years and much reading before they discovered that so many serious constitutional symptoms might be possible from a combination of extensive allergic and cellular immune problems.

Without treatment, I would not be alive today. Dr. Calabrese has not only saved my life, but my reason for being. I am now a college junior with a 4.0 average, close friendships, and a close bond to my family. I have political causes, hobbies, and interests that I am able to pursue and enjoy.

Treatment has been neither a smooth road nor an easy one. When I was ten, I "relapsed" and snuck foods I wasn't supposed to eat, causing myself to have severe reactions. As I have become an adult, I have learned the importance of eating the way I do, living the way I do, and taking my preservative-free allergy shots and transfer factor shots regularly. My compliance with treatment, as much as the treatment itself,

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has enabled me to have a fulfilling and productive life.

Before I was appropriately diagnosed and treated by Dr. Calabrese, much of my life was a blur. Some of the allergic reactions were so severe, it's best that I don't remember much of it any more. Instead, I focus on speaking Russian and am learning to speak Arabic. I'm a history buff, fascinated with the memories of ancient peoples. I can take exhaustive class notes, write fiction, and am an amateur jeweler. Nearly everything that brings beauty and meaning to my life has only been possible because of Dr. Calabrese and the treatment she has given me.

Unfortunately, everything that I have gained while I have been on treatment can be lost much more easily and quickly than it was achieved. When I was weaned off treatment, in late middle school and early high school, I definitely experienced a profound backslide. First, I began to have delayed allergic reactions again. Then I have stomach and muscle pain nearly constantly, get colds and the flu frequently, and have more frequent and severe asthma attacks, which can be life threatening.

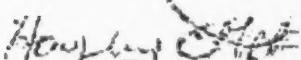
As soon as I realized how sick I was becoming again, my parents took me back to Dr. Calabrese. I learned that I cannot do without treat

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ment. My illness, untreated would have robbed me of my intellect, my ability to make friends, and my ability to return the love and strength my family has bestowed upon me. It would, and has, stolen my ability to communicate, to play, and even to think properly. Treatment has stolen them back.

I'd have no life without this treatment. My illness has forced upon me an awareness of just how fragile my life is and the ability for me to do daily activities that people normally take for granted are. Without treatment, this would vanish.

I declare, on this the 14th day of July 2008, in the city of Albuquerque, New Mexico, that this information is true and correct under penalty of perjury.



Hayley Otto:

A A - D O R O T H Y C A L A B R E S E , M D

Bronx H.S. of Science 1969

New York University B.A. 1972

Columbia College P & S M.D. 1976

CPMC Clinicopathological Lab CPMC
worked four years clinical chemistry tests

Columbia Presbyterian Medical Center
CPMC Hospitals - three-year residency.

Kaiser Permanente 1980 - 1981 ran an al-
lergy-immunology program for refractory
patients

Solo regional allergy-immunology consulta-
tive practice 1982 – present

Longstanding member in good standing of
ACAAI, AMA, CMA, and Association of
American Physicians and Surgeons.

Dr. Calabrese's TF program and laboratory
was set up with her colleague, immunolo-
gist Dr. Said Youdim who worked with her
for years at her solo regional practice, until
he retired. He trained with Robert A. Good,
MD, PhD, DSc, FACP, the father of mod-
ern immunology at the University of Min-
nesota Medical School. Dr. Youdim had
worked at a national center for over a dec-
ade treating this same orphan population
with this Th1-Th2 immunoregulatory de-
fect. Dr. Calabrese's lab director who testi-
fied to the Contractor on 11-20-03, was
Scott Matthews, M.P.H., Yale University
Medical School, Department of Public
Health faculty.